DOCTORAL THESIS

Talk about what might be helpful:

Relating meta-therapeutic dialogue to concrete interactions and exploring the relevance for therapeutic practice

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Talk about what might be helpful:
Relating meta-therapeutic dialogue to concrete interactions and exploring the relevance for therapeutic practice

by

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Abstract

This thesis investigated how clients and therapists discuss the means by which clients can work towards their therapeutic goals. Cooper et al. (2016) termed such discussions *meta-therapeutic communication* or *meta-therapeutic dialogue* and Cooper and McLeod (2011) recommend carrying them out since outcomes are robustly related to whether the client accepts the therapeutic strategy as appropriate for their needs (e.g. Horvath et al., 2011). This thesis undertook the first discovery-oriented, Conversation Analysis (CA) study of how clients and therpaists actually carry out meta-therapeutic discussions. It represents a sustained attempt to bridge the practice-research gap and highlights the conceptual and practical challenges in doing so.

42 audio-recorded pluralistic therapy sessions were sampled across seven therapist-client pairs. Before carrying out the CA study proper, it was necessary to conceptually link broad descriptions of meta-therapeutic dialogue to participants' concrete actions in therapy sessions. This involved a review of related concepts (Chapter Two), as well as a detailed conceptualization of how therapists' *stocks of interactional knowledge (SIKs)* (Peräkylä & Vehviläinen, 2003) regarding meta-therapeutic dialogue might demonstrably link with their concrete actions as described by CA findings (Chapters Three through Five). Therapists' questions to clients about what might be helpful were selected as a likely site for meta-therapeutic dialogue and were subjected to an in-depth CA investigation of the practical issues participants themselves treated as important in their interactions around these questions (Chapters Six through Eight).

Findings show how some apparent opportunities for meta-therapeutic dialogue are less facilitative of clients' independent input, and can sometimes be interactionally coercive. There is evidence that facilitating dialogical opportunities for talking about what might be helpful may require the therapist to move back-and-forth between opposing positions, such as treating the client as potentially unknowing but still also holding open a space for their contribution. These findings extend existing SIKs regarding meta-therapeutic dialogue by specifying some concrete considerations therapists orient to during such endeavours. Some practical similarities between meta-therapeutic dialogue and problem-solving/solution-focused approaches are also highlighted.

The research for this project was submitted for ethics consideration under the reference PSYC 14/ 140 in the Department of Psychology and was approved under the procedures of the University of Roehampton's Ethics Committee on 08.09.14.

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Chapter One: Introduction

1.1. Preliminary illustration of phenomenon

The interactional data investigated are taken from pluralistic therapy sessions (Cooper & McLeod, 2011). In Extract AI, we join the client and therapist 54 minutes into the assessment session, their first session together.

Extract AI *Session#0/Start54minutes/PairA*

```
 1  T:   °Oki dokey.°
 2       (0.5)
 3  C:   Ehm:,
 4  T:   .hh °eh-° (.) tell ↑me (.) Mary, >>have you<< ↑↑had any
 5       previous therapy?
 6       (.)
 7  T:   Sorry to com[e ac]ross you there. [No? ] .hh uhm have you got
 8  C:                [No. ]               [°No°]
 9  T:   any i:dea >>but I think that we- you said you had a friend
10       who's a#: th[erapi]st, .hh do you have any i:dea abou#t, .h if
11  C:                [Mm.  ]
12  T:   there was a therapy, if you could choose a therapy
13       [or something.]
14  C:   [.hhh         ] I th:↑ink
```

In line 1, the therapist acknowledges what the client has been saying, using "°Oki dokey.°", which suggests they consider the client to have reached the end of what they have been talking about. In line 3, the client moves to hold the conversational floor with "Ehm:," but then the therapist takes the conversational floor by posing a question about previous therapy to the client in lines 4-5. Almost immediately, the therapist apologizes to the client for interrupting (line 7). Here, in lines 1-7, we can see the therapist working to achieve a shift to a different topic and the practical difficulties they come up against in doing so – for example, both parties apparently starting turns-at-talk and then having to socially manage an apparent instance of interruption. These practical considerations form an integral part of all human interactions, including interactions in therapy sessions. However,

they are not usually acknowledged in clinically-focused texts on how to conduct therapy (Strong & Sutherland, 2007). My thesis will focus on how the practical considerations involved in actions such as topic shifts are integral to carrying out some key therapeutic tasks in pluralistic therapy. Such practical considerations are often tacit and unarticulated, occurring at a pre-reflective level (Hepburn, Wilkinson & Butler, 2014; Madill, 2015; O'Hara, 2012; Peräkylä, 2011; Polkinghorne, 1992). However, their tacit nature does not detract from their importance as the nuts-and-bolts of all human interaction, including therapy. Indeed, these are the essential building blocks of human social institutions like therapy and everyday interactions (Heritage, 1984).

Returning now from these broader considerations back to the extract, after the therapist apologizes for interrupting the client, they proceed to pose another question in lines 7-13. This question invites the client to give their views on what kinds of therapeutic approach might be helpful. Such invitations are important acts in Cooper and McLeod's (2011) pluralistic therapeutic approach and our data extract enables us to see how one therapist works to practically achieve such an invitation and to see how the client responds. The therapist's invitation never quite reaches full grammatical formation as a question at any point during its production: "uhm have you got any i:dea >>but I think that we- you said... .hh do you have any i:dea abou#t, .h if there was a therapy, if you could choose a therapy or something" (lines 7-13). We might wonder why the therapist has produced the question in this kind of way. What kinds of considerations in this context are they orienting to in producing it thus? This thesis explores these issues with a view to learning more about how these conceptually important actions actually get done in concrete practice.

1.2 Research contexts

I will now detail some contexts essential for understanding the aims and scopes of this thesis.

1.2.1 Common factors research

Common factors research has consistently indicated that agreement between the client and therapist regarding therapeutic goals and tasks is moderately but robustly related to therapeutic

outcomes (Horvath et al., 2011). Norcross and Lambert (2011) further argue that since client factors alone account for the largest proportion of the explained variance in therapeutic outcomes, therapists should endeavour to ensure the therapy is optimally personalized to suit each client's needs and existing strengths: "begin by leveraging the patient's resources and self-healing capacities; emphasize the therapeutic relationship and so-called common factors; adapt everything to the patient's characteristics." (p.13)

Wampold (2017) has since moved to temper such conclusions regarding how much client factors contribute to outcomes. For example, he presents evidence that effective therapists are able to facilitate therapeutic change across different clients, regardless of specific client factors. However, Wampold and Imel (2015) nevertheless also found that the client's acceptance of therapeutic goals and methods as appropriate is significantly and positively related to outcomes. They further suggest the client's acceptance is important in facilitating positive expectations about therapy and their motivation to achieve change. Thus, a consistent conclusion from common factors research is that positive therapeutic outcomes are related to how much the client agrees with and accepts the therapeutic plan as being appropriate for their needs.

Stiles (2013) presents a critique of linear cause-effect understandings of psychotherapy which further extends this conclusion from common factors research. He argues that the essence of the therapeutic relationship is to *appropriately respond* to emerging information from each client. Such appropriate responsiveness by the therapist should help to facilitate and maintain the client's agreement with the therapeutic plan. Stiles' critique highlights evidence for how effective therapeutic practice involves the therapist flexibly adjusting to emerging information from the client at multiple levels, including treatment planning, active-listening, turn-taking, attunement and adjusting ongoing interventions (e.g. Hatcher, 2015; Stiles, Honos-Webb & Surko, 1998; Owen, & Hilsenroth, 2014). In summarising recent engagement with the responsiveness critique, Kramer and Stiles (2015) note how there have been efforts to develop "explicitly responsive strategies" to emerging information from the client (p.286). Cooper and McLeod's (2011) *pluralistic psychotherapy and counselling* is an example of such strategy. My thesis comprises an observational study of this

therapeutic approach which has been developed as a means of practically implementing the above conclusions from common factors research (Cooper & McLeod, 2011).

1.2.2 Pluralistic counselling and psychotherapy therapy

Pluralistic counselling and psychotherapy is a collaborative-integrative framework for psychotherapeutic practice, which draws upon two basic principles; firstly, that "a wide range of different treatment methods and strategies can be helpful for different clients" and, and secondly, "that therapists should work closely with their clients to help them identify the treatment approach that most suits their therapeutic goals and preferences" (Cooper et al., 2015, p.7). The first, integrative or pluralistic principle holds that different therapeutic methods can be differentially helpful for different clients at different times, while the second, collaborative principle emphasizes that the client and therapist should collaborate to create a personalized therapy that makes optimal use of what is currently helpful for that particular client. This principle of collaboration furthermore assumes that clients have pre-existing resources, including their own ideas about what will be helpful for them. The task of the pluralistic therapist is therefore to assist the client in identifying and mobilizing strategies for change that are personally viable for the client (McLeod & Cooper, 2012).

1.2.3 Meta-therapeutic dialogue

Cooper and McLeod (2012) proposed that this collaborative-integrative framework can be implemented through "talking to clients about what they want from therapy and how they think they may be most likely to achieve it" (p.7). Such talk has subsequently been interchangeably designated in the pluralistic therapy literature as *meta-therapeutic communication* and *meta-therapeutic dialogue* (e.g. Cooper et al., 2016; Papayianni & Cooper, 2017). The primary purpose of meta-therapeutic dialogue is to collaboratively enhance the fit of the therapy to the individual client by initially agreeing upon suitable therapeutic goals and methods for achieving these goals, as well as subsequently discussing how the client is experiencing the ongoing therapeutic process and

progress (Cooper et al., 2016; Papayianni & Cooper, 2017). Its processes are therefore largely similar to shared-decision making processes in which health professionals and clients work together to select treatments based on clinical evidence and clients' informed preferences (Cooper et al., 2016). Therapeutic process and outcome measures (e.g. Robinson, Ashworth, Shepherd & Evans, 2006) can also be used to facilitate meta-therapeutic dialogue (Papayianni & Cooper, 2017), but whether or not measures are used, the process is supposed to be *dialogical* or mutual, such that both clients' and therapists' contributions are valued and given due regard, with a view to working together to eventually reach a consensus (Cooper & McLeod, 2011).

1.2.3.1 Meta-therapeutic dialogue regarding therapeutic methods Given the technical eclecticism inherent in pluralistic therapy, an essential meta-therapeutic focus is for therapists to talk with clients about which therapeutic methods and approaches might be helpful in achieving their therapeutic goals. Indeed, such conversations about therapeutic methods can be considered an essential and distinctive feature of pluralistic therapy. Cooper and McLeod (2011) describe therapeutic methods as "resources for facilitating change" (p.92). They specific that such resources include practices outlined in the counselling and psychotherapeutic literature as well as resources or strategies within particular cultures or which are idiosyncratic and unique to individuals. Table 1.1 contains some specific examples of therapeutic methods mentioned by McLeod and Cooper (2012). Meta-therapeutic dialogue with respect to therapeutic methods consists of conversations between the client and therapist regarding which methods or approaches to use, and subsequently, conversations which evaluate these methods and discuss whether or not the method needs to be adjusted or changed for another one (Cooper et al., 2016). Cooper and McLeod (2011) further note from their clinical experience how such conversations may also have benefits such as facilitating moments of reflection for the client around "broader issues" such as self-efficacy and learning how to learn (p.110).

Table 1.1: Examples of therapeutic methods, adapted from McLeod and Cooper (2012)

reflecting on thoughts that might be irrational or maladaptive
becoming more aware of emotions
planning behaviour changes
use of self-help materials and cultural resources, such as movies
identifying social resources
appreciating the significance of cultural-political factors (e.g. racism) in the client's life
expressive art-making
identifying and making use of physical interventions to alleviate depression (e.g. dietary changes, exercise)

1.2.4 Summary of contexts for pluralistic therapy

Cooper and McLeod (2011) position pluralistic therapy as a practical initiative for explicitly implementing the common factors research conclusion that collaboration between therapists and clients regarding therapeutic goals and methods is important in developing positive therapeutic outcomes. In addition, as discussed above, Kramer and Stiles (2015) have also identified pluralistic therapy as a pragmatic strategy to encourage clinicians to explicitly practice responsiveness with clients. This section will now situate pluralistic therapy within some other relevant contexts.

Pluralistic therapy has been developed in the context of counselling psychology in the U.K. (e.g. Woolfe & Strawbridge, 2010). Both pluralistic therapy and counselling psychology advocate technical eclecticism as part of a post-modern stance, holding that various therapeutic modalities can be differentially helpful in different contexts and for different clients at different times (Cooper & McLeod, 2012; Vermes, 2017; Woolfe & Strawbridge, 2010). However, pluralistic therapy is distinctive in systematically advocating technical eclecticism through pluralistic therapists' and clients' collaborative, meta-therapeutic discussions of what might be helpful.

Pluralistic therapy can also be considered a humanistic, ethical initiative due to its declaration of shared values with person-centred and existential therapies. For example, Cooper and McLeod (2011) follow Rogers (1957) in advocating a deep, idiographic respect for the client's unique experiences and capacities as a self-directing, autonomous being. Furthermore, following Rogers and other theorists like Laing (1965) and Buber et al. (1997), the therapeutic relationship is prized as a genuine, respectful and mutual meeting of the client and therapist. With these values, pluralistic

therapy positions itself as harnessing a range of available therapeutic modalities and the client's existing resources, through respectful engagement or *dialogue* with the client as a unique person (Hanley, Sefi & Ersahin, 2016). Dialogue within the therapeutic encounter can itself be considered to be an ethical endeavour, since it advocates a mutually respectful way of communicating, in which all perspectives are sought out and valued (Cooper & McLeod, 2011).

Finally, pluralistic therapy has been developed in the context of contemporary political and economic discourses which describe the clients and patients as *consumers* of healthcare (Vermes, 2017). These discourses have developed alongside the creation of healthcare policies, which emphasize that patients and clients should have *choice* from a range of healthcare options and that they should be involved in decision-making regarding their treatments (e.g. Department of Health, 2015). While these developments in the healthcare sector claim to validate and promote a humanistic and client-centred value-base similar to that of pluralistic therapy, they may also be used in advancing political and economic policies such as the privatization of healthcare services (Priebe 2017) and the individualization of the causes of psychological distress (Vermes, 2017). The similar emphasis on client participation in healthcare decisions through meta-therapeutic dialogue shows some connection between pluralistic therapy and these contemporary political and economic directions.

1.3 Research rationale

1.3.1 The need for practice-based research on meta-therapeutic dialogue

Numerous researchers have highlighted a lack of knowledge regarding how concepts related to meta-therapeutic dialogue, such as how collaboration and shared decision-making can be practically implemented (Angell & Bolden, 2015; Cooper & McLeod, 2011; Norcross & Wampold, 2011; Papayianni & Cooper, 2017; Priebe, 2017; Priebe & McCabe, 2008; Thompson & McCabe, 2012). They conclude that there is a need for research which specifies and details what participants actually do in applying such concepts. This need might be considered an instance of a *gap* between the

existing research and clinical literature and what therapists do in real-life therapy sessions (Henton, 2012; Woolfe, & Strawbridge, 2010). Addressing this gap requires *practice-based* or process-focused research focused on detailing what therapists and clients actually do in routine therapy sessions (Barkham et al., 2010; Henton, 2012). Findings from such research could produce practice-relevant findings to inform all therapeutic approaches which emphasize collaborative practice, including pluralistic therapy.

Cooper and McLeod (2011) link the need for practice-based research regarding the concept of collaborative practice with a related and similar need for research into meta-therapeutic dialogue. For example, they observe that there may be strategies for doing this which have yet to be discovered, particularly around helping clients build on their resources and participate in the therapeutic work (p.160). Furthermore, McLeod and Cooper (2012) encourage therapists to use their existing, individual knowledge bases of therapeutic skills when working pluralistically. There is therefore a need to document the variety of strategies that therapists might employ with respect to meta-therapeutic dialogue. In addition, detailing what therapists and clients actually do during meta-therapeutic dialogue would also inform the continuing practice, training and development of pluralistic therapy. For instance, recently-qualified therapists reported finding it challenging to merge pluralistic theory with practice (Thompson & Cooper, 2012). This implies that training in pluralistic therapy requires more focus on the concrete skills necessary to practically carry out the therapy.

Another reason for addressing the practice-research gap pertains to how there is often a multitude of complexities or *interactional dilemmas* involved in implementing macro-level concepts such as meta-therapeutic dialogue. These interactional complexities and dilemmas are frequently not detailed in clinically-focused descriptions of these concepts (Toerien et al., 2011a; Stokoe, 2013; Strong, Pyle & Sutherland, 2009). For example, it is often acknowledged in the pluralistic therapy that clients can be initially reluctant to participate in meta-therapeutic dialogue (e.g. Cooper & McLeod, 2011; Cooper et al., 2016; McLeod, 2013). The authors briefly specify some potential strategies for managing such reluctance; for example, Cooper and McLeod (2011) encourage the

gradual development of a *culture of feedback* in the face of initial client reluctance. However, the specific interactional complexities of how therapists actually work to address such practical dilemmas in carrying out meta-therapeutic dialogue still require practice-based research.

1.3.2 Focusing on meta-therapeutic dialogue regarding therapeutic methods

As elaborated in section 1.2.3, meta-therapeutic dialogue can take place with respect to understandings of the client's problems, the client's therapeutic goals, methods which might help them reach these goals and reflections on their progress towards these goals. There is a particular need for practice-based research on how therapists and clients carry out meta-therapeutic dialogue with respect to therapeutic methods. This need stems from the practical importance of in-session discussions of therapeutic methods for implementing the collaborative-integrative framework underpinning pluralistic therapy. Such discussions between therapists and clients facilitate the intersection of the collaborative and integrative principles, since they comprise the vehicle for implementing its technical eclecticism in a collaborative manner.

As it stands, there is almost no existing research on meta-therapeutic dialogue with regard to therapeutic methods, neither in the pluralistic therapy literature nor in the field of psychotherapy research more generally. In contrast, there is a steadily growing body of practice-based research with high relevance for meta-therapeutic discussions around goals. This research mainly concerns how collaboration and consensus can be effectively achieved around goals, both in adult psychotherapy (e.g. DeFife & Hilsenroth, 2011; Lindheim, 2017; Michalak & Holtforth, 2006; Oddli et al., 2014; Tryon & Winogrand, 2011), and in other healthcare settings such as physiotherapy (e.g. Parry, 2004; Schoeb, 2014) and child and adolescent mental health settings (e.g. Law & Jacob, 2013; Pender et al., 2013). The current project was therefore required to contribute to a similar development of research on meta-therapeutic dialogue with regard to therapeutic methods.

In their systematic literature review, Thompson & McCabe (2012) also noted how specific features of communication, which might be deemed collaborative (e.g. information-giving, discussing the practicalities of treatment specifics) were less studied, although positively associated

with adherence to mental-health treatments. They therefore also argued for further research on the more task-oriented (i.e. as opposed to more goal-oriented) aspects to collaboration. An investigation of meta-therapeutic dialogue with respect to therapeutic methods is one means of working towards fulfilling this need, due to the similar focus on how clients and therapists discuss and come to agreement regarding how to work towards achieving clients' therapeutic goals.

Finally, research on the practice of meta-therapeutic dialogue with respect to therapeutic methods might eventually contribute towards the development of an overall adherence measure for pluralistic therapy. Developing such a measure needs to overcome the practical hurdle comprising how pluralistic therapy can potentially be carried out in highly diverse ways due to its technical eclecticism. Given that meta-therapeutic dialogue with respect to therapeutic methods is a distinctive and essential feature of pluralistic therapy, it may be feasible to base an adherence measure on instances of such talk.

To summarize the rationale for the current project as outlined so far, there is a need for research which can contribute towards addressing the research-practice gap around meta-therapeutic dialogue with respect to therapeutic methods. This research would need to be practice-based and, thereby, would involve a sustained observational investigation of how clients and therapists actually carry out such meta-therapeutic dialogue. There is furthermore a need for findings from this investigation to be presented in a manner which informs ongoing practice and training in meta-therapeutic dialogue and other similar therapeutic endeavours. The current research project worked to address these needs.

1.3.3 The ethical need for this practice-based research

This section will discuss a further rationale for the current project, derived from some ethical claims and considerations linked to pluralistic therapy.

As discussed in Section 1.2.4, Cooper and McLeod (2011) position pluralistic therapy as an ethical endeavour since the client is respected as a unique individual and explicitly invited to participate in mutually determining the therapeutic direction, through selection and ongoing

adjustment of therapeutic goals and methods. The ethical claim here rests on the presumption that the client's autonomy is being respected and that the therapist is creating sufficient dialogical spaces and invitations for the client to mutually participate if so inclined. It is necessary to interrogate whether these claims of ethical and dialogical practice, formulated at the conceptual macro-level, survive the aforementioned practice-research gap and are oriented to by participants at the micro-level of moment-by-moment interactions.

One possibility is that the complexities of carrying out meta-therapeutic dialogue in real-life therapy sessions may occasionally override its implementation in an ideal, ethical, prescribed manner. For example, alongside Proctor (2017), Guilfoyle (2003) and White and Epston (1990), the developers of pluralistic therapy acknowledge that there are inevitably differences in expertise, authority and power between clients and therapists, so that, for example, the client is likely to defer to the therapists' perceived expertise (Cooper & McLeod, 2011; Cooper at al., 2016). Interviews with clients also indicate that some clients may initially be reluctant to answer such questions due to such deference and, also, due to the client's perceptions of their own inadequacy (Eliacin et al., 2015; Rennie, 1994; Gibson, 2016). However, Cooper and McLeod still nonetheless assume that genuine meta-therapeutic dialogue is possible despite such asymmetries in the relationship. The validity of such an assumption requires empirical interrogation. Otherwise, there is a danger that these macro-level ethical claims remain unsubstantiated at the level of actual interactions between clients and therapists.

It is also possible that the proclaimed ethical ideals of pluralistic therapy might be altered in order to facilitate their implementation in local contexts. For instance, Vinson (2016) found that medical practitioners used patient empowerment discourses to construct a practitioner discourse which she identified and labelled as *constrained collaboration*. In training environments, trainers used this discourse to advocate the preservation of medical authority in concrete interactions, while still ostensibly fulfilling the contemporary cultural mandate to empower patients. This shows how the particular, practical details of how macro-level concepts, such as meta-therapeutic dialogue, are actually implemented, is all-important in terms of determining whether the concrete practice stays

close to the macro-level ethical ideas. The issue at stake here is not the macro-level, categorical one of *what* therapists do in implementing their proclaimed therapeutic approach, but a micro focus on *how* they do so in the unfolding moments of therapy (Sutherland, Turner & Dienhart, 2013).

Evans (2012) notes how psychotherapeutic innovations co-occur alongside socio-political developments, such that the psychotherapeutic innovations may have wider political ramifications than intended. Pluralistic therapy is a candidate for such an innovation, co-occurring, as it does, alongside contemporary political drives to privatize healthcare and conceptually individualize the social, political and economic causes of psychological distress (Vermes, 2017). The scope of the current thesis will not extend to investigating the broader political ramifications of pluralistic therapy. However, practice-based findings on how meta-therapeutic dialogue with regard to therapeutic methods is actually carried out could subsequently be used to illustrate contemporary political discussions regarding healthcare privatization and individualization of psychological distress. This discussion of the links with the broader political context will be briefly resumed in Chapter Nine, in light of the practice-based findings presented by the current project.

In summary, a further rationale for the current research comprises the need for an investigation of what real-life attempts at meta-therapeutic dialogue look like and how these compare to textbook descriptions of how to go about ethical and dialogical practice.

1.3.4 The need for an inductive, observational method to conduct this research

In this section, the existing research on pluralistic therapy will be briefly summarized. Alongside this summary, brief arguments will be presented as to why an inductive, observational methodology, is necessary for conducting a practice-based investigation of meta-therapeutic dialogue. Conversation Analysis will be briefly presented as a suitable methodology in this context.

A recent multisite, non-randomised, pre-/post-intervention study showed that pluralistic therapy achieved acceptable therapeutic outcomes, retention rates, and user satisfaction (Cooper et al., 2015). However, the quantitative process and outcome measures used in this study provide very limited data regarding how therapists and clients actually carried out meta-therapeutic dialogue

regarding methods (Silverman, 1997; Stiles, 2008). For example, the use of the *Helpful Aspects of Therapy* form (Llewelyn, 1988) and the *Session Rating Scale* (Duncan et al., 2003) involved clients indicating which descriptions of the session they felt were most accurate e.g. "The therapist's approach is a good fit for me" (Duncan et al., 2003). However, summary sentences like this are insufficient for obtaining practice-based data regarding what clients and therapists actually, concretely did in the session.

One frequently used means of gathering data as to how therapists and clients actually carry out therapeutic processes like meta-therapeutic dialogue is to interview clients regarding how they experience these processes (e.g. Gibson, 2016) and regarding the occurrence of therapeutic change (e.g. Cooper et al., 2015). Therapists have also been interviewed regarding their experiences of carrying out pluralistic therapy (e.g. Thompson & Cooper, 2012) and Papayianni and Cooper (2017) have thematically coded pluralistic therapists' notes forms for the subject matter and temporal focus of meta-therapeutic dialogue, as well as the point of occurrence within the session. The common link between these studies is that they are based on participants' self-reports regarding their interactions in therapy sessions. Such studies can highlight or indicate some findings relevant to the actual practice of meta-therapeutic dialogue. For example, meta-therapeutic dialogue on the topic of therapeutic methods was the most frequently occurring topic in Thompson and Cooper's (2017) sample of therapist note forms. Furthermore, Antoniou et al. (2017) used post-therapy change interviews to investigate clients' perspectives regarding helpful aspects of pluralistic therapy. Clients reported perceiving pluralistic therapists as helpful when they were accepting and respectful but also challenging.

Unfortunately, there are several major problems in using clients' and therapists' self-reports to gather data regarding the concrete practice of meta-therapeutic dialogue. First, these reports can contain vague descriptions as to the details of how concrete actions and projects were actually carried out. For example, the client reports from the Antoniou et al. (2017) study can be considered somewhat contradictory in that they found it helpful when therapists were accepting and respectful but also challenging. These descriptions therefore require expansion and further specification to

resolve such apparent contradictions so as to clearly inform future practice and training. Second, self-reports are vulnerable to gaps in participants' memories and also gaps in participants' ability to describe interactions as they actually happened at an adequate level of detail (Hepburn, Wilkinson & Butler, 2014). Such gaps in participants' ability to describe interactions in a sufficient level of detail may be in part due to tacit practices which therapists may engage in without realizing (Madill, 2015; Peräkylä, 2011; Polkinghorne, 1999). Third, participants' reported views regarding the therapy are observably constructed in local social contexts. Participants' reported views therefore cannot be regarded as straightforward reflections or representations of their experience, since they are formed in the context of local interactions with the interviewer and the interview agenda (Elliott, 2010; Leudar et al., 2008; Potter, 2012; Veen et al., 2011).

Observational research, which uses audio or video recordings of therapy sessions as data, can start to address the above problems outlined with regarding to self-report and interview-based data (Coutinho et al., 2014; McCabe, 2017; Papayianni & Cooper, 2017). This is in large part due to the taking up of a non-subjective observer position since the recorded data is then publicly available and can be replayed and/or transcribed, in order to check and interrogate researchers' descriptions or codes and to further specify phenomena.

Many authors have additionally argued that observational research has to be inductive or discovery-oriented, if the research aim is to identify previously unknown, unarticulated or tacit aspects of therapeutic practice (Madill, Widdicombe & Barkham, 2001; Silverman, 1997; Stiles, Hill & Eliot, 2015; Stiles, 2008; Stokoe, 2013). Indeed, Rogers' (1957) influential person-centred model of the counselling process was based on discovery-oriented, inductive research, approaching the data with little or no assumptions and listening multiple times in order to describe what is occurring in adequate and accurate detail. In contrast, many ostensibly observational studies actually employ deductive reasoning since they involve searching for theoretical codes which have been derived *a priori* (Silverman, 1997; Stiles, Hill & Eliot, 2015). Findings from such deductive studies have limitd capacity to uncover previously unnoticed aspects to phenomena, since such details have been assumed or pre-specified before data has been collected and analysed (Silverman, 1997).

Conversation Analysis (CA) comprises an inductive observational methodology, suitable for conducting discovery-oriented research on how clients respond to each other on a moment-by-moment basis in therapy sessions (Stiles, Hill & Eliot, 2015). The moment-by-moment or micro-level focus of CA is one means of addressing the research-practice gap between the macro-level concept of meta-therapeutic dialogue and determining how clients and therapists might concretely carry out such a practice (Peräkylä & Vehviläinen, 2003). As such, CA is well-placed to respond to Cooper and McLeod's call to "pool the collective wisdom and inventiveness of clients and therapists around how to carry out therapy in a collaborative manner" (p.36). As discussed earlier, such detailed, observational data is especially relevant since tacit knowledge may be organised at a level of specificity difficult for therapists and clients to remember and describe (e.g. Hepburn, Wilkinson & Butler, 2014; Madill, 2015). Furthermore, discovery-oriented analyses of observational data can highlight interactional dilemmas which re-occur across therapists and clients in carrying out meta-therapeutic dialogue, as well as previously unarticulated and various ways of managing these dilemmas. Findings from this CA research can usefully contribute to developing implications for therapeutic practice and training (Strong, Pyle & Sutherland, 2009). Findings can also be used to interactionally specify the macro-level, ethical prescriptions of meta-therapeutic dialogue in real-life practice.

1.4 The current research project

1.4.1 Summary of aims

The primary aim of this research project was to contribute towards addressing the research-practice gap around meta-therapeutic dialogue with respect to therapeutic methods. I worked to achieve this by conducting a Conversation Analytic investigation of how pluralistic therapists and clients demonstrably engaged in meta-therapeutic dialogue with respect to therapeutic methods. To ensure the relevance of findings to therapy practice, this investigation involved a focus on any re-occurring interactional dilemmas observably arising in the course of such talk and the ways in which

participants managed these dilemmas. A further component of this aim was to relate findings from the discovery-oriented, practice-based CA investigation related to textbook descriptions of, or guidelines concerning, ethical and dialogical practice.

I subsequently attempted to present implications from these findings in a way which could practically inform training and practice in meta-therapeutic dialogue, thereby further substantially contributing to lessening the research-practice gap. Another anticipation was that these findings would also inform other therapeutic endeavours involving the use of collaborative and dialogical practices.

1.4.2 Thesis structure in relation to research aims

Chapter Two presents a review of a network of existing concepts and research, which are conceptually related to the current research focus on meta-therapeutic dialogue with respect to therapeutic methods. I derived this conceptual network from Cooper and McLeod's (2011) descriptions of meta-therapeutic dialogue. Included in the network are the existing constructs of *meta-communication*, *collaboration*, *shared decision-making*, *preferences*, *resource-oriented therapies* and *dialogue*. Chapter Two represents an original contribution in the following ways. Firstly, it comprises a focused conceptual review, which highlights some new distinctions, as well as some previously unacknowledged conceptual overlap, between meta-therapeutic dialogue with respect to therapeutic methods and the existing network of related concepts. Secondly, Chapter Two offers the first ever review of existing observational research with conceptual and practical relevance for meta-therapeutic dialogue with respect to methods. This review also serves to further explicate the context and rationale for the current research project.

Chapter Three comprises a discussion of the relevant methodological background, as well as specific considerations arising when using CA for the current research aims. This discussion incorporates an in-depth interrogation of the potential for CA to lessen the research-practice gap around meta-therapeutic dialogue. I present conceptual arguments for the importance of practically maintaining distinctions between conceptually different tasks when using CA to lessen the practice-

research gap, as well as the resolution of the potential problem of CA being an interaction-near, but practice-far methodology.

Following on from these conceptual and methodological clarifications, Chapter Four demonstrates how the notion of meta-therapeutic dialogue with respect to methods can be connected with participants' concrete actions through the thematic code, *talk about what might be therapeutically helpful.* These illustrations are the first collection of transcribed examples which detail a variety of ways in which therapists and clients can carry out meta-therapeutic talk regarding therapeutic methods.

Chapter Five presents an overview and justification for the decision to work to achieve the research aims through an in-depth analysis of one sub-group of instances of *talk about what might be therapeutically helpful*, namely, when therapists ask for clients' views regarding what might be therapeutically helpful. The primary justification for this in-depth focus is that these are instances in which therapists demonstrably attempt to invite the client to participate in meta-therapeutic dialogue regarding therapeutic methods. These instances therefore hold high relevance for the research focus on how this form of meta-therapeutic dialogue is actually carried out. Furthermore, these instances can be conceptualized as junctures in the interaction, which create the possibility for a subsequent meta-therapeutic focus to the talk. There are several interactional dilemmas which arise around such junctures, which also merit in-depth analysis since how therapists resolve these dilemmas is highly relevant for ongoing practice and training in pluralistic therapy and other therapeutic approaches with similar collaborative aspects. As well as detailing and evidencing this justification, Chapter Five also precisely defines the inclusion criteria for these questions asking for clients' views on what might be helpful. This process of defining the inclusion criteria also gives rise to some new distinctions, which are informative for therapeutic practice, regarding how therapists go about creating opportunities for talking about therapeutic methods.

Chapters Six, Seven and Eight comprise the in-depth analysis of instances in which therapists ask questions to invite clients' views regarding what might be therapeutically helpful. Chapter Six focuses on some of the initial contexts in which therapists pose these questions and explicates some

associated interactional dilemmas. Chapter 7 reports on a comparative investigation of the different ways in which therapists can design or produce these questions and how this impacts on how clients can relevantly respond. Chapter 8 explores the aftermath of these questions and considers various ways in which therapists can respond to clients' responses. In this chapter, I also use these findings to conceptualize some dialogical features of various therapist responses and relate this conceptualization to descriptions of ethics and dialogue by the developers of pluralistic therapy.

Chapter 2: Literature review

2.1 Aim and scope

As noted in the Chapter One, meta-therapeutic communication or meta-therapeutic dialogue is "the process of talking to clients about what they want from therapy and how they think they may be most likely to achieve it" (Cooper & McLeod, 2012, p.7). Thus, meta-therapeutic dialogue encompasses discussions between clients and therapists regarding any issues are relevant to whether the client is achieving their therapeutic goals and ways in which the therapy has been, is being or could be conducted (Papayianni & Cooper, 2017). These issues include understandings of the client's problems, the therapeutic goals and methods and feedback and reflections on the ongoing therapeutic process of facilitating the client to reach their goals (Cooper et al., 2016). Papayianni and Cooper (2017) emphasize how meta-therapeutic dialogue aims to optimize the helpfulness of the therapy to suit each individual client. They also specify that meta-therapeutic dialogue should *explicitly* invite the client to enter into a dialogue about the past, present or future helpfulness of therapeutic approaches. The aim of such dialogue would be to develop a contract regarding the shape and structure of therapeutic activities and approaches, as distinct from the content to be addressed in the sessions (Hanley, Sefi & Ersahin, 2016; Lee, 2006).

This review focuses on research with relevance for meta-therapeutic dialogue with respect to therapeutic methods as opposed to talk about therapeutic goals. That is to say, the focus will be on research relevant to how clients and therapists discuss what the therapist and client might do to help the client achieve therapeutic goals rather than discussing what the goals might be in the first place. The rationale for focusing on meta-therapeutic dialogue regarding methods was discussed in Chapter One. The main thrust of this rationale pertained to the importance of such discussions regarding therapeutic methods and the lack of existing observational research regarding how clients and therapists actually go about this in practice.

Following Papayianni and Cooper (2017), the distinction between therapeutic tasks and methods made in earlier pluralistic therapy literature (e.g. Cooper & McLeod, 2011), was not used.

So the term therapeutic methods is used to refer to both general strategies or *tasks* for achieving goals and also the specific activities or *methods* used to achieve these. In particular, the aim of the current review was to conduct a narrative review of existing observational research regarding how meta-therapeutic dialogue regarding methods gets done in practice. Throughout the review, I will discuss how the observational research reviewed has conceptual and practical relevance for how clients and therapists actually do meta-therapeutic dialogue with respect to methods.

2.1.1 Distinguishing meta-therapeutic dialogue from meta-communication

Papayianni and Cooper (2017) describe how meta-therapeutic dialogue builds upon *meta-communication*, a practice first described and advocated by Rennie (1994, 1998). Rennie (1998) defined meta-communication as talk within therapy sessions which explicitly focuses on articulating what the client or therapist are currently experiencing. The aim is for both participants to become aware of previously unknown aspects of each other's experience of the therapy. Meta-therapeutic dialogue is similar to meta-communication in the sense that meta-therapeutic dialogue constitutes *meta*-talk, that is, talk within therapy sessions about the therapeutic process itself. However, Papayianni and Cooper clarify that meta-therapeutic dialogue differs from meta-communication in specifically focusing on articulating what clients want from therapy and how they think they should work towards that. So rather than focusing on here-and-now experiences (e.g. Eubanks-Carter, Muran & Safran, 2015; Kiesler, 1988), the *meta-therapeutic dialogue* descriptor is reserved for talk about the client's goals and about current, and potential, therapeutically helpful and unhelpful factors in making progress towards these goals.

In sum, meta-therapeutic dialogue is conceptually related to meta-communication since it consists of talk about the therapeutic process itself. Two essential differences between meta-therapeutic dialogue and meta-communication are: one, that meta-communication is restricted to exploring the here-and-now experiences and motives of the client and therapist, whereas this here-and-now component is not essential for meta-therapeutic dialogue. And two, that meta-therapeutic dialogue is topically restricted in focusing on shared understandings of the client's difficulties,

therapeutic goals and therapeutic methods, whereas meta-communication focuses on here-and-now experiences in the therapy session.

2.1.2 Review rationale and aims

As noted in Chapter One, there is a general need for research on how clients and therapists actually do meta-therapeutic dialogue with respect to therapeutic methods (Cooper & McLeod, 2011; Cooper et al., 2016; Papayianni & Cooper, 2017). However, as noted by Cooper & McLeod (2011) and Cooper et al. (2016) there are existing concepts, and associated research, which are related to meta-therapeutic dialogue. The current review thus aims to review a selection of research with conceptual and practical relevance for meta-therapeutic dialogue regarding methods. By *conceptual relevance*, I mean conceptual aspects of related concepts, such as collaboration, which can help to clarify and extend our theoretical understanding of meta-therapeutic dialogue. By *practical relevance*, I mean existing research findings which can inform our understanding of how meta-therapeutic dialogue is concretely implemented in real-life therapy sessions.

As will be further outlined in section 2.1.3, the selection of areas of research related to meta-therapeutic dialogue will be justified with reference to the summary of competencies for pluralistic therapists, as laid out in the McLeod and Cooper (2012) *Pluralistic Therapy for Depression* manual used in the data for the current project. The conclusions from this review will also inform the focus and direction of the research for the current project.

This review will predominantly focus on observational research as opposed to research based on participants' reports. As outlined in the Chapter One, there is a general need for discovery-oriented, observational research regarding meta-therapeutic dialogue (Cooper & McLeod, 2011; Coutinho et al. 2014; Lepper & Mergenthaler, 2007; Papayianni & Cooper, 2017; Priebe, 2017; Priebe & McCabe, 2008; Safran & Muran, 2006; Thompson & McCabe, 2012). Focusing on observational research enables the identification and discussion of existing concepts and research with the most relevance for the current project aims of conducting discovery-oriented, observational research regarding meta-therapeutic dialogue. This relevance of observational

research enabled critical comparisons of various other observational methodologies with Conversation Analysis, which further informed the discovery-oriented, inductive direction of the current research project.

To summarize, this review aimed to investigate existing observational research in order to articulate conceptual and practical relevance for meta-therapeutic dialogue regarding methods. The relevancies highlighted in this review would be used to conceptually clarify meta-therapeutic dialogue as well as to inform the direction of the current research project.

2.1.3 Selection of studies

Observational research was considered to include any research based on audio or video recordings of therapy sessions. Thus the research methods of the studies considered for this review were varied and included deductive, theoretically-derived coding systems, as well as more discovery-oriented, inductive methods like Grounded Theory, Conversation Analysis and microanalysis.

Observational research was selected from areas conceptually related to meta-therapeutic dialogue about methods. A conceptual area was assumed to be related if it was mentioned in the competencies for pluralistic therapists outlined in McLeod and Cooper's (2012) manual, *Pluralistic Therapy for Depression*. This was the manual used by therapists in the current data corpus (cf. Chapter Three). Among these competencies for pluralistic therapists, McLeod and Cooper describe the need for "collaborative conversations" regarding the therapeutic goals and methods, thus demonstrating a link between meta-therapeutic dialogue and existing therapeutic concepts, such as collaboration (e.g. Ribeiro et al., 2013a), therapeutic alliance (e.g. Horvath et al., 2011), shared decision-making (e.g. Cooper et al., 2016). There is also an emphasis on the desirability of meta-therapeutic dialogue of course being carried out in a dialogical manner, thus displaying a conceptual relationship with the notion of *dialogue* in therapeutic contexts (e.g. Bavelas et al., 2014). The McLeod and Cooper summary also identifies how the pluralistic therapist should be responsive to the individual client's *preferences*, thereby highlighting a link with the related conceptual area of therapy personalization (e.g. Swift, Callahan & Vollmer, 2011). Finally, McLeod and Cooper (2012)

also highlight how the therapist should "mobilize" "the client's own ideas" about what might be helpful for them in achieving therapeutic change, including making use of "cultural/community resources". This demonstrates a conceptual link between meta-therapeutic dialogue regarding methods and similar existing therapeutic concepts and approaches, including solution-focused and resource-oriented therapies (e.g. Flückiger et al., 2010).

All of these conceptually related areas have been previously referenced in key pluralistic therapy texts (e.g. Cooper & McLeod, 2011; McLeod, 2013; Cooper & Dryden, 2016) as well as in the McLeod and Cooper (2012) manual. These key texts provided a starting point for the current review, in terms of indicating the related conceptual areas in which to search for relevant existing observational research. The current review thus constituted a review of research in this conceptual *network* of pluralistic therapy. As such, it forms a clarificatory, narrative review. Furthermore, the examples of this conceptual research network which have been identified, reviewed and presented are *indicative*, that is as opposed to a *systematic* review being conducted.

A snowballing search strategy was used. The starting point was the citations of conceptually-related areas in the key pluralistic texts mentioned above. These cited texts were obtained and their conceptual relevance was reviewed. *Google Scholar* was then also used to check other citations of these texts and whether any of these citations comprised observational research. Citations involving observational research were then also obtained, reviewed and subsequently checked as to whether any other observational studies had cited them. If so, then these studies were obtained and reviewed as well. Citations within studies obtained were also checked for relevance. This checking of citations within found studies means that some studies discussed in the current review may have been conducted prior to the development of the pluralistic therapy literature. I also supplemented the literature review with my knowledge of existing Conversation Analysis studies, as an additional source of relevant observational research. The review focused on studies within the last ten years. This more recent focus facilitated the current project to engage with recent developments in the field.

A review was undertaken of three aspects of each study obtained. First, conceptual descriptions of related areas were reviewed for coherence and distinctions with meta-therapeutic dialogue. Second, the exact observational method used was noted and evaluated. Finally, the findings were reviewed for their conceptual and practical relevance to meta-therapeutic dialogue.

2.1.4 Presentational structure

The six related conceptual areas mentioned above will be reviewed under the headings indicated in Table 1. For each heading, the conceptual areas will first be defined and an overview of the state of this research field will be presented. Then some indicative observational research for this conceptual area will be discussed.

Table 2.1: Conceptual areas related to meta-therapeutic dialogue included in literature review

Conceptual area related to meta-therapeutic dialogue	**Heading in current review**
collaboration (e.g. Ribeiro et al., 2013a) working alliance (e.g. Horvath et al., 2011)	*Collaboration (Section 2.2)*
shared decision-making (e.g. Salyers et al., 2012) preferences (e.g. Swift, Callahan & Vollmer, 2011)	*Shared Decision-Making & Client Preferences (2.3)*
resource-activation (e.g. Flückiger et al., 2010) solution-focused therapy (e.g. Jordan, Froerer & Bavelas, 2013)	*Resource-Oriented Therapeutic Approaches (2.4)*
dialogue (e.g. Bavelas et al., 2014)	*Dialogue (2.5)*

2.2 Collaboration

2.2.1 Conceptual overview and need for observational research

Ribeiro et al. (2013a) summarize conceptual elements of collaboration outlined in previous studies. These elements include the client's "active involvement" in making proposals about the therapeutic direction, "participation" in the therapeutic activities and "affinitive, cooperative and engagement behaviours" (p.295). Ribeiro et al. also note how collaboration is commonly conceptualized as an

ongoing, emergent process which is dependent upon effectively combining the contributions of both client and therapist. Collaboration thus involves partnership and mutuality in shaping the course of therapy and requires the therapist and client have to develop and maintain some consensus regarding what might be therapeutically helpful for this particular client. This involves adjusting therapeutic methods "to suit the patient's needs, expectations and capacities" (Horvarth et al., 2011, p.56). In this sense, adjusting the therapy to the individual client and their particular situation can be considered an essential aspect of collaboration (Norcross & Wampold, 2011). Thus, collaboration can be considered to be essential for meta-therapeutic dialogue in action.

The *Working Alliance Inventory* is a widely-used, pan-theoretical operationalization of collaboration in therapy (Hovarth et al., 2011), which is additionally broadly used to represent the clinician-patient relationship (Thompson & McCabe, 2012). The *working alliance* construct is defined as the degree to which the client and therapist have achieved *agreement* on the goals and tasks of the therapy, alongside the quality of the *bond* between client and therapist (e.g. extent to which the client feels understood and respected) (Bordin, 1979). Across a broad range of contexts, a collaborative alliance between clients and therapists has been shown to be moderately and robustly positively related to treatment outcomes (Hovarth et al., 2011).

Several researchers have highlighted the need for conceptual and analytic clarity when utilizing the working alliance construct for research and when drawing clinical implications. Oddli and Rønnestad (2012) cite Hatcher and Barends' (2006) argument that the working alliance should be considered conceptually superordinate to the therapist's concrete actions or techniques, such that working alliance might be deemed an umbrella concept, encompassing for a multitude of concrete actions by therapists. Furthermore, Stiles (2013) argues how constructs like the working alliance are often far from being genuinely descriptive of what participants do. He argues that the alliance construct is not something that inherently resides in participants' actions, but a summative, value-judgement about participants' actions, made either by observers or by the participants themselves. Unfortunately, such value-judgements provide no specific information regarding what

participants actually do in therapy. As such, there is consensus for the need for discovery-oriented, observational research regarding how clients and therapists collaborate.

2.2.2 Indicative observational research

In a call for research which moves beyond the development of new versions of measures which do much than just evaluate the presence or absence of the alliance, Safran and Muran (2006) identified "the critical task" as being "to continue to clarify *how"* and "*in what way*" [emphasis added] collaboration plays a central role in change processes (p.290). Their research program develops the alliance construct by investigating ostensibly less collaborative manifestations of the therapeutic relationship, in the form of *ruptures* and, relatedly, how these ruptures might be *repaired*. They propose that collaboration could usefully be re-conceptualized as *negotiation*, in order to emphasize that much of what could be considered collaboration involves working through disagreements and tensions. In an observational research stream, Eubanks-Carter, Muran and Safran (2014) developed the *Rupture Resolution Rating System* (3RS) for coding what they deem to be markers of alliance rupture and repair in therapy sessions. In the 3RS coding system, client behaviours (i.e. *withdrawing* and *confrontation*) are used as potential markers for ruptures and therapist behaviours as markers for potential repairs. The authors clarify that the 3RS attempts to rate the quality of collaboration rather than the mere presence of agreement or disagreement. As an example, they describe how participants could apparently be working together very smoothly, but pursuing goals and tasks that are not suited for that particular client. This distinction between apparent agreement versus the quality of the collaboration is relevant to how therapists practice meta-therapeutic dialogue with respect to methods; for example, since a client might only minimally or superficially agree with a suggestion regarding what might be helpful, but the therapist might take this as substantial agreement and proceed to implement it.

In support of the clinical relevance of the 3RS, there is evidence that therapists' failure to address ruptures is linked to patient dropout (Eubanks-Carter, Muran, & Safran, 2010). However, research utilizing the 3RS is nonetheless vulnerable to the same criticisms outlined in Chapter One.

For example, raters have to use the wide-ranging list of markers provided in the manual to interrogate the possibility of each suspected instance of rupture and/or repair. This means that the raters are primed and ready to look for instances of rupture and repair. As such, there is a risk that raters are imposing these categories upon participants' actions, when there is little evidence to suggest that participants themselves are orienting to the possibility of rupture. Indeed, Coutinho et al. (2014) compared the 3RS observational method of identifying ruptures in therapy sessions with a self-report method using the *Working Alliance Inventory* (WAI). They found that the 3RS detected more ruptures than the WAI. However, they acknowledge that – as well as being explained by the efficacy of the 3RS in detecting ruptures and by limitations in participants' recall or awareness – this discrepancy may also be due to raters "over-evaluating alliance ruptures" (p.440) and that there may be disagreement between what raters and participants consider to be ruptures. To resolve this dilemma, Coutinho et al. (2014) advocate always using and comparing more than one source of data regarding potential ruptures and repairs. As discussed in Chapter One, another possibility would be to conduct more discovery-oriented research which attempt to inductively describe participants' concrete actions rather than using ready-made categories, which raters are primed, and thus potentially biased towards, applying. An example of such discovery-oriented research in to alliance ruptures and repairs is Voutilainen, Peräkylä and Ruusuvuori's (2010a) Conversation Analysis (CA) of how a therapist used the client's misalignment as a therapeutic resource. In particular, they highlighted the interactional practices leading to the rupture and how the therapist subsequently moved to repair this by explicitly topicalizing the prior interactions in the session. Muntigl and Horvath (2014) also used CA to specify some ways in which therapists achieved re-affiliation through verbal and non-verbal resources after clients had expressed explicit disagreement.

Moving back now to a focus on research more directly relevant to collaboration around therapeutic methods, Ribeiro et al. (2013a) developed the *therapeutic collaboration coding system* (TCCS), which they construe as having emerged from discovery-oriented explorations of audio-recordings. The TCCS tracks therapists' and clients' moment-by-moment interactions, with a specific emphasis on whether the client *validated* or *invalidated* the therapist's just-prior intervention. The

TCCS was developed to conceptually integrate how clients and therapists actually collaborate on a moment-by-moment basis with Leiman and Stiles' (2001) *therapeutic zone of proximal development* (TZPD) model of how clients and therapists work together to achieve therapeutic progress. Ribeiro et al. (2013a) constructed what they called "data-driven" sub-categories to describe participants' concrete actions when talking about the client's presenting problem (p.303). Examples of these sub-categories include *confronting, confirming, specifying information, extending, clarifying, expressing confusion*.

Some of the conceptual structure of the TCCS and TZPD might usefully inform discovery-oriented findings regarding meta-therapeutic dialogue. For example, the TCCS criterion of whether or not the client *validates* the therapist's just-prior intervention might be a useful jumping off point for investigating the practice meta-therapeutic dialogue as well – although participants' actions would need to be specified in much more detail. Furthermore, following Leiman and Stiles' (2001), Vgotsky's *zone of proximal development* concept could also conceivably be helpful in conceptualizing clients' readiness to participate in various therapeutic activities, which might also be discussed during meta-therapeutic dialogue regarding methods.

Compared to the working alliance construct, Ribeiro et al.'s sub-categories indeed specify more about what therapists and clients concretely do when they are judged as collaborating. However, these data-driven codes may still subsequently impede comprehensive, non-simplistic descriptions of what clients and therapists are actually doing. This is since the TCCS does not require in-depth attention to how clients and therapists themselves are treating their actions. Furthermore, the TCCS focuses on collaboration during constructions and discussions of the client's problems rather than focusing on discussions regarding therapeutic goals and methods *per se*. The TCCS does not therefore alleviate the need for discovery-oriented, observational research on meta-therapeutic dialogue with respect to methods.

Oddli and Rønnestad (2012) undertook a discovery-oriented, observational study of how experienced therapists actually accomplished "the technical aspects" of forming a working alliance with clients (p.176). Oddli and Rønnestad used this phrase "technical aspects" to refer how

therapists initially prepared clients for, and introduced, therapeutic techniques and solution strategies. Their study is therefore highly relevant for the focus of the current project on meta-therapeutic dialogue with respect to methods. They analysed recordings of sessions using constructivist Grounded Theory. In their sample of nine dyads with experienced and predominantly integrative therapists, they found that there were few instances of explicit negotiation between therapists and clients regarding what might be therapeutically helpful. They then went on to investigate what they labelled as more implicit manifestations of technical aspects of the alliance. These implicit manifestations ranged from therapist interventions apparently supporting the client's agency (e.g. underlining the client's authority; exploring the client's prior or ongoing solution strategies) to those interventions which displayed the therapist's authority (e.g. immediately implementing a therapeutic method without discussion; challenging the client). Oddli and Rønnestad noted how clients in their study rarely acted in ways to reduce the asymmetries of power and knowledge between them and therapists. In a recommendation with possible relevance for the practice of meta-therapeutic dialogue, they assert that emphasizing the client's ability to choose or disagree may just obscure the reality of existing asymmetries between therapists and clients. This therefore highlights the urgent, ethical need for an investigation of how meta-therapeutic dialogue is actually carried out with clients and whether and how clients can be facilitated to overcome these asymmetries.

As Oddli and Rønnestad acknowledge, their study's focus on what they consider to be implicit manifestations of collaboration renders their findings less objective, since their descriptions of participants' actions may derive from the authors' research interests as opposed to what participants were actually working to achieve with their actions. So there is a need to further investigate their findings using a more objective methodology, such as Conversation Analysis, which focuses on elucidating participants' publicly available interactions with each other. Furthermore, meta-therapeutic dialogue is defined as *explicit* dialogue between participants regarding the goals and methods of therapy (Papayianni & Cooper, 2017), which galvanizes the need for research investigating such explicit instances.

Conversation Analysis (CA) research constitutes an inherently discovery-oriented approach. There are a number of existing CA studies with findings highly relevant to the practice of meta-therapeutic dialogue with respect to methods. These CA studies do not fall prone to the criticisms made of the (coding and Grounded Theory) studies discussed above, since the essential aim of CA involves explicating what participants themselves treat as important in their moment-by-moment interactions (Heritage, 1984). This approach therefore vastly reduces the risk that findings involve the imposition of categories upon participants' actions which the participants themselves would have disagreed with during the interaction. Sutherland, Turner and Diehart (2013) conducted what they describe as a CA-informed analysis of one instance of an expert therapist's negotiating therapy methods with a couple in couple's therapy. Specifically, the negotiation centred around the therapist's preference to explore interpersonal dynamics and the clients' focus on changing one partners' intrapersonal functioning. They develop a concept of *responsive persistence* to describe how the therapist manages this negotiation. The broad thrust of this concept is that the therapist responds or adjusts to the clients' prior talk, while still also persistently furthering their agenda. According to Sutherland, Turner and Dienhart, the therapist can be responsively persistent when engaging in a wide variety of actions, ranging from *persistently involving* (p. 478, 479) the clients by eliciting their perspectives and preferences to *persistently focusing on the client's strengths* and by the therapist *adjusting their understandings in light of the clients' understandings* (p.480). However, aside from these indicative examples, this concept of responsive persistance has not yet been systematically linked to the concrete practices of therapists and clients. Furthermore, Sutherland, Dienhart and Turner (2013) conclude that *responsive persistence* may differently manifest across different therapeutic approaches. Thus the concept is of limited use in describing moment-by-moment, concrete actions of clients and therapists, since its usage may be dependent upon conceptual acceptance of a particular therapeutic paradigm.

Ekberg & LeCouteur (2012, 2014a) have produced research which exemplifies how CA can be used to systematically describe how clients and therapists concretely engage in actions relevant to collaboration, across client-therapist pairs. For example, with the aim of interactionally specifying

collaborative empiricism in CBT (e.g. Wright et al. 2006), Ekberg & LeCouteur (2012) demonstrated how therapists designed their proposals for behavioural change in such a way as to emphasize a high degree of optionality to clients. Ekberg and LeCouteur (2014a) subsequently investigated how cognitive behavioural therapists used information-soliciting questions to co-implicate the client in the decision-making process regarding helpful behavioural changes the client could make, for example, arranging some social activities with family and friends. In investigating how therapists invited clients to participate in planning therapeutically helpful changes, this study has high relevance for the practice of meta-therapeutic dialogue with regard to methods. Ekberg and LeCouteur (2014a) demonstrate how clients showed much less resistance in these co-implication sequences compared to when therapists unilaterally made a proposal regarding behavioural change. The authors additionally dug deeper beyond the collaborative features of the therapist's invitation and found that therapists shaped the suggestion-making activity more actively than the initial information-soliciting question indicated. Therapists achieved this shaping through anticipatory completions, re-formulations and reported speech and this shaping may have been in the service of making the clients' answers more psychotherapy-relevant.

Ekberg and LeCouteur's findings strike at the core of how therapists concretely attempt to be more or less collaborative. The findings have both practical and conceptual relevance for the practice of meta-therapeutic dialogue with regard to methods. Practically they show how clients tend to collaborate more with questions than proposals, but that therapists can still subtly shape the client's answers to questions such that, overall, the therapist exerts a considerable degree of influence on the decision-making process – both in defining a question agenda for the client to align with and by subsequently shaping the content of the client's answer. Both practically and conceptually, these findings demonstrate the interactional complexities of achieving collaborative practice in which neither party dominates but in which the therapist has to mould the interactions in a therapeutically-relevant manner. Ekberg and LeCouteur call for further CA research in this area, specifically regarding how therapeutic activities might be "jointly produced" by clients and therapists

(p.74). Such CA research would have clear relevance when investigating collaborative conversations regarding therapeutic methods in pluralistic therapy.

2.3 Client preferences and shared decision-making

2.3.1 Conceptual overview and need for observational research

Shared-decision making (SDM) is described as occurring when health professionals and clients work together to select treatments based on clinical evidence and clients' informed preferences (Coulter & Collins, 2011; Edwards & Elwyn, 2009). Papayianni and Cooper (2017) describe meta-therapeutic dialogue as being parallel to SDM in the wider healthcare field. The authors specify that meta-therapeutic dialogue may, at times, be focused less around specific treatment decisions but aside from this, they consider meta-therapeutic dialogue and SDM processes to largely overlap in encouraging collaboration regarding identifying treatment goals and how the healthcare activity can help them achieve these. Existing observational research on SDM will therefore usefully contribute to our conceptual and practical understanding of how clients and therapists go about meta-therapeutic dialogue regarding which therapeutic methods might help the client to achieve their therapeutic goals.

There is currently no conclusive evidence regarding the relationship between shared decision-making in the psychological therapies and therapeutic outcomes (Coulter, 2017; Duncan, Best and Hagen, 2010; Gibson et al., submitted) nor between shared decision-making and adherence to mental health treatments (Thompson & McCabe, 2012). Similarly to Oddli and Rønnestad's (2012) finding regarding the lack of explicit implementation by therapists of technical aspects of the working alliance, Gibson et al.'s (submitted) review suggests that shared decision-making is either predominantly absent or else implicit in the psychological therapies. Also similarly to recent calls regarding collaboration research, there have been calls for research which focuses on how SDM is, and can be, concretely implemented by practitioners and clients (e.g. Gibson et al., submitted; Scholl & Barr, 2017; Slade, 2017). In their review of observational research regarding the implementation

of SDM in healthcare contexts, Land, Parry and Seymour (2017) argue that arranging our understanding of decision-making around the point of explicitly committing to a decision can be helpful, since participants' actions immediately prior to, and during this point, can then be understood as being "commitment relevant" (p.19). That is, participants can be seen to produce their actions around this point in ways which progress, obstruct or delay explicit agreement regarding a course of action.

Discussing patients' treatment preferences occurs prior to the commitment point, but is still an essential part of shared decision-making processes (Fukui et al., 2014; Land, Parry & Seymour, 2017; Landmark, Svennevig & Gulbrandsen, 2016). In the psychotherapeutic and counselling context, there is some research investigating how client preferences can be measured and incorporated into the therapy. Client preferences refer to ''the behaviors or attributes of the therapist or therapy that clients value or desire'' (Swift, Callahan & Vollmer, 2011, p. 302). Systematic reviews have shown a modest but consistent relationship between preferences and both treatment completion and therapeutic outcomes (Lindhiem et al., 2014; Swift, Callahan & Vollmer, 2011). Therapy personalization tools, such as interview schedules (Vollmer et al., 2009) and preference measures (e.g. Bowen & Cooper, 2012; Cooper & Norcross, 2016) have been developed to indicate the strength of clients' preferences across various dimensions of therapist and client approaches activities, such as therapist/client directiveness, emotional reserve and challenge/support. At relevant points in the therapeutic process, these tools are intended to facilitate collaboration between therapists and clients in discussing different possible therapeutic approaches and tasks and in selecting and refining these, thereby contributing to shared decision-making processes. As such, these personalization tools can also be considered a type of decision-making aid.

Personalization tools, such as those listed above, have in common that they create formal or designated opportunities for clients and therapists to discuss predefined therapeutic approaches and tasks. However, there have been recent calls for evaluations of SDM and its effects which go beyond simply considering the impact of momentary treatment decisions. For example, Coulter

(2017) advocates that the concept of SDM is investigated as an ongoing process encompassing several distinct stages and tasks, including discussions to clarify patients' goals and priorities, agreement of realistic objectives, solving of specific problems, and implementing and reviewing agreed plans. Furthermore, it has been argued that explicit efforts at personalization also need to extend beyond lists of predefined possibilities in order to create more informal opportunities, arising spontaneously within therapy sessions, for accessing and integrating other therapeutic possibilities which are already be known to the client (McLeod, 2013; Sparks & Duncan, 2016; Wall et al., 2016). These other therapeutic possibilities might include existing strategies utilized by the client and extra-therapeutic social and cultural resources, including culturally-specific understandings, activities and knowledge derived from the client's particular social identity and related experiences (Cooper & McLeod, 2011; Sparks & Duncan, 2016; White & Epston, 1990; McLeod, 2013; Bohart & Tallman, 2010). Such a focus would ensure that therapy personalization is based on categories which are personally meaningful for the client (McLeod, 2015). For example, Wall et al. (2016) noted how clients with alcohol problems seemed to report distinctive, problem-related knowledge, which would be in danger of being missed if only generic preference dimensions were used to enquire about client knowledge. There is considerable conceptual overlap here between what I have distinguished as *informal opportunities for discussing preferences* and recommendations stemming from resource-oriented therapeutic approaches. These approaches also advocate facilitating and focusing on other therapeutic possibilities and resources which the client is able to access themselves, beyond what is defined or offered in the immediate setting of the therapy sessions. Existing observational research regarding how therapists can foreground client resources will be reviewed in section (2.4).

2.3.2 Indicative observational research

Moving now to research which focuses on interactions closer to the commitment point, Salyers et al. (2012) developed a coding system for describing features of decision-making in psychiatric visits at community mental health centres. A decision was defined as "a verbal commitment to a course of

action addressing a clinical issue" (p.780). Raters made a judgement as to whether a decision had occurred and then rated the decision in terms of a number of descriptors, including complexity, the patient's role, whether alternatives were discussed, whether the clinician assessed the patient's understanding, whether the patient's preferences were discussed and what the level of agreement was between clinician and patient regarding the decision. The authors reported a notable lack of instances in which the clinician checked the patient's understanding or in which the patient's desired role in decision-making was discussed. This has relevance for the current focus on meta-therapeutic dialogue, since it highlights the possibility that meta-talk about the decision-making process itself occurs highly infrequently. Salyers et al. also reported that clinicians and patients *fully agreed* 79% of the time. Inter-rater reliability was 100% regarding instances of full agreement. However, a general weakness of this study is that the authors do not specify in detail how the codes were defined nor what the other options were apart from *fully agreed*. This creates substantial vagueness regarding which instances counted as *fully agreed*. For example, it might be that there were a small number of available categories for raters to select from, such that the code *fully agreed* actually just corresponds to lack of an explicit disagreement, as opposed to indicating clear or emphatic agreement between clinician and patient.

In a study motivated by similar difficulties in developing coding systems to identify and measure SDM processes, Landmark, Ofstad and Svennevig (2017) compared CA findings and coding systems regarding medical consultations and found that there were large variations in SDM tallies across coding systems. They argue that CA findings can explain this disparity by highlighting interactional complexities, for example, when a professional apparently engages in SDM by eliciting patient preferences, but does so in such a way that the patient is constrained in how they can respond. One implication of their findings is that SDM processes can be difficult to tally into a reliable number of occurrences and that detailed analyses, such as CA, may be more suited to investigating SDM processes.

Aside from the Ekberg and LeCouteur (2012, 2014a) studies already discussed in relation to collaborative processes, there is currently little existing, published CA work on decision-making

processes in psychotherapeutic contexts *per se*. Some CA studies on decision-making in psychiatric and other healthcare consultations will be briefly discussed, however an important caveat throughout this discussion is that SDM processes will likely manifest differently across distinct institutional contexts, including psychotherapy (Gibson et al., submitted; Land, Parry & Seymour, 2017; Pilnick & Zayts, 2016). For example, Thompson and McCabe (2012) note that sharing treatment preferences may be more challenging in mental health care due to difficulties in establishing a shared understanding about non-physical symptoms in the first place. Also, psychiatric consultations can involve discussing medication plans, which is not relevant to psychotherapy and counselling settings. Nonetheless, as demonstrated by Land, Parry and Seymour's (2017) review, "despite differences, common activities exist" (p.18). Thus, in the remainder of this section, there is an assumption that this CA work on SDM in psychiatric and medical consultations can still tentatively inform our understanding of practical considerations when undertaking meta-therapeutic dialogue regarding therapeutic methods in psychotherapeutic and counselling contexts.

Quirk et al. (2012) conducted an exploratory investigation of decision-making between psychiatrists and patients regarding antipsychotic medication. They presented their findings on a continuum, which they argued depicted decisions in which the psychiatrist put more or less pressure on the patient to accept their recommendation. The Quirk et al. study is informative in highlighting the possibility of a range of ways in which decisions can be taken in more or less mutual ways. However, they did not provide clear definitions for their coding of decisions as *pressured*, *directed* or *open*. This shows the need more rigorous analysis of how participants themselves are constructing and treating decisions and the need to provide observable and clearly depicted grounds for making comparisons across cases.

In their systematic literature review, Land, Parry and Seymour (2017) mapped decision-making practices in recordings of healthcare interactions which had been previously investigated by twenty eight Conversation Analysis studies. These previous CA studies had all focused on health/illness-related decision making and Land, Parry and Seymour now aimed to examine their findings in relation to the SDM concept. The authors categorized the communication practices

identified by the prior CA studies as belonging to one of four elements of decision-making process: *Broaching,* which they defined as relevant actions occurring before a commitment point is reached, includes the practices of flagging up that a commitment point is approaching and eliciting patient perspectives about decisions. Interactional practices occurring at other stages of the decision-making process, as identified by the authors, were (ii) *putting forward a course of action*, especially regarding how courses of action are pre-emptively presented in order to minimize the possibility of resistance from the patient (iii) *committing or not (to the action put forward)*; and (iv) *practitioners' responses to patients' resistance*. These categories form a useful schema for conceptualizing how existing CA findings can inform our understanding of SDM practices in healthcare interactions.

Land, Parry and Seymour conclude similarly to Ekberg and LeCouteur (2014a) that ostensibly collaborative sequences are still substantially guided by therapists. For example, a series of CA studies investigating SDM processes in medical contexts has also found that actions which seem facilitative of SDM, such as eliciting patient preferences or listing possible treatment options can, depending on how these actions are designed, simultaneously constrain the patients' choices and subtly create pressure to accept the medic's recommendations (e.g. Landmark, Svennevig & Gulbrandsen, 2016; Landmark, Ofstad & Svennevig, 2017; Toerien, Shaw, & Reuber, 2013). However, CA studies of decision-making in psychiatric consultations have also demonstrated how psychiatrists can work to render the decision-making process more mutual even when the treatment trajectory is non-negotiable (Land, Parry & Seymour, 2017). For example, Angell and Bolden (2015) showed how psychiatrists' use of accounts or rationales for treatment shows them working to lessen asymmetry and build consensus with patients regarding a particular treatment. Kushida & Yamakawa (2015) also found that psychiatrists in Japan displayed orientations to patients' readiness to commit to a treatment option. Psychiatrists achieved this by switching between cautious unilateral declarative evaluations ("It might be better to change") in environments which were not decision-ready and a more inclusive, interrogative (e.g. "How about changing to X?") in environments in which a decision was treated as acceptably imminent, for example, following agreement of a shared

diagnosis. Thus CA studies continue to explicate the pragmatic intricacies of implementing interactional ideals like collaboration and SDM.

In a comprehensive and systematic manner, Thompson (2013) also used CA to investigate decision-making practices around medication in psychiatric consultations. She found evidence that psychiatrists frequently treated the decisions to be made as optional, formatting them as *proposals* (*we*-formulations) and *suggestions (I*-formulations) rather than *pronouncements* regarding the treatment direction. Her work usefully conceptualizes these different formats for decision-making as indexing different degrees of decisional responsibility, with pronouncements and suggestions entailing more responsibility for psychiatrists since they displayed endorsement of a particular course of treatment. Strikingly, patients' in Thompson's study displayed more overt resistance to proposals and offers, that is, the formats characterized by less psychiatrist responsibility and more patient responsibility due to the orientation in these formats to patient preferences. Thompson concluded that in several such cases patients were not only resisting the proposed or offered treatment, but also the responsibility entailed by the proposals or offers as decisional vehicles. Toerien et al. (2011a) also documents cases in which patients sought a recommendation from neurologists after being presented with multiple options. Given this evidence that patients recurrently counter decisional responsibility in healthcare encounters, these researchers re-assert the consideration, first proposed by Pilnick and Dingwall (2011), as to whether mitigated paternalism might be a more realistic labelling of decision-making processes currently referred to as *shared* and *collaborative*. These findings raise the open empirical question as to whether the same considerations might be relevant when therapists attempt meta-therapeutic dialogue. For example, whether clients treat decisional responsibility as being acceptable and whether concepts like SDM are practically suited to therapeutic contexts.

A final conceptual issue arising from our discussion of the observational research concerns the eliciting of client preferences and decision-making processes: As highlighted by Cooper and McLeod (2011) and Cooper et al. (2014), meta-therapeutic dialogue, incorporating SDM and collaboration, is conceptualized as a two-way process, in which there is mutual sharing of views with

the aim of reaching agreement or consensus in which both parties have contributed. However, as flagged up by these authors, and also by Land, Parry and Seymour (2017), if the professional takes on the patient and clients preferences and adjusts accordingly, then this process is far from a shared or mutual one. This points to a conceptual tension between therapy personalization, as a potentially monological adjustment to fit with client preferences, and SDM and collaboration, as mutual and dialogical processes. Similarly, therapy personalization might be considered monological, if a particular type of therapy is given to a client on the basis of predetermined criteria, which the client is not given an opportunity to discuss or query (e.g. Cheavens et al., 2012). These more monological instances of personalization might dubbed *non-collaborative personalization*. In contrast, the therapy personalization which is supposed to be facilitated by meta-therapeutic dialogue in pluralistic therapy would be more appropriately dubbed *collaborative personalization*. Sutherland, Turner & Dienhart (2013) have characterized such a process of mutual negotiation as involving the possibility that "not only clients' understandings and preferences may get sacrificed or revised, but also those of the therapist" (p.472). The current thesis will attempt to focus on elucidating this concept of collaborative personalization.

2.4 Resource-oriented therapeutic approaches

2.4.1 Conceptual overview and need for observational research

Crucial to meta-therapeutic dialogue, collaboration, therapy personalization and shared decision-making is the emphasis on the therapist and client sharing knowledge about what might be helpful, including the client's existing knowledge (Cooper & McLeod, 2011; McLeod, 2013; McLeod & Cooper, 2012; Matthias, Salyers & Frankel, 2013; Sparks & Duncan, 2016; Wall et al., 2016). This emphasis shows a conceptual relationship with resource-oriented therapeutic approaches, which also advocate seeking clients' views about what might be helpful in order to promote their existing coping and personal, social and cultural resources (Priebe et al., 2014). One rationale for utilizing resource-focused approaches stems from the meta-analytic conclusion that "patients contribute the

lion's share of therapeutic success" (Norcross & Lambert, 2011, p.14**;** cf. also Sparks & Duncan, 2016). Norcross and Lambert estimate that, when unexplained variance is taken into account, approximately 30% of the variance for total therapeutic outcomes derives from client factors alone, with the therapeutic relationship accounting for a further 12%. As acknowledged by Cooper and McLeod (2011), this estimation provides a strong impetus for facilitating clients to optimally utilize their existing resources and resilience.

In their conceptual review of resource-oriented therapeutic approaches, Priebe et al. (2014) concluded that these are often vague in terms of which resources are used and in how they are mobilized. Priebe et al. further note how resource-oriented approaches are usually considered separately without an analysis of their commonalities. In what follows, I will discuss conceptual similarities and differences between meta-therapeutic dialogue and two resource-oriented approaches referenced in the pluralistic therapy literature, which aim to foreground clients' knowledge and resources. These approaches are *resource-activation* (e.g. Flückiger et al., 2009) and *solution-focused brief therapy* (e.g. Molnar & de Shazer, 1987). I will then present an indicative review of observational research on how these approaches are implemented and draw some practical and conceptual implications for meta-therapeutic dialogue with respect to methods.

Gassmann and Gawe (2006) define *resource activation* as referring to interventions by the therapist, which facilitate and maintain the therapeutic bond, while also "reinforcing the specific strengths and abilities of the patient" (p.2). As such, the definition of resource activation in this study conceptually combines the *therapeutic bond* element of the working alliance construct with the idea of reinforcing the client's existing resources. Similarly, Flückiger and Grosse Holtforth (2008) initially list client resources that they conceptualize as being helpful in psychotherapy, including "individual qualities (e.g., success at work), interactional qualities (e.g., relationship to a good friend), motivational preparedness (e.g., important life goals), and personal skills (e.g., cross-country skiing)" (p.2). The authors specify that resource-activation then involves exploring these qualities with the client and reminding the client of them. Flückiger et al. (2009) also describe further elements of resource activation as being discussion of the client's therapeutic goals, and possible

solutions and approaches for achieving these. Here again, we see substantial conceptual overlap between the resource activation concept and collaboration and the working alliance. Thus, the resource activation construct consistently intersects with meta-therapeutic dialogue, since both involve eliciting the client's existing resources and collaboratively discussing therapeutic means of facilitating the client's achievement of their therapeutic goals.

Regarding the overall efficacy of resource-oriented approaches, Cheavens et al. (2012) assessed participants' strengths and deficits in four areas related to cognitive-behavioural interventions (i.e., cognitive strategies, interpersonal skills, behavioural activation, and acceptance practices) and then randomly assigned participants to therapy modules which emphasized one of these four domains. They reported evidence (considered preliminary due a small sample size of 34 clients) that personalizing treatment to clients' relative strengths (i.e. *capitalization model*) led to better outcome for depression than treatment personalized to clients' relative deficits (i.e. *compensation model*). Flückiger et al. (2016) then randomly assigned clients to three different therapist priming conditions for the implementing CBT for Generalized Anxiety Disorder (GAD), consisting of an adherence priming (i.e. compensation model) condition and two different priming conditions drawing on a capitalization model i.e. resource priming regarding the client's strengths and abilities and supportive resource priming regarding their existing social supports. All three conditions showed significant reduction of symptoms over time but the two capitalization conditions indicated faster symptom reduction. These studies thus show promising but inconclusive results regarding the efficacy of capitalization over compensation models. The results of these studies are promising for meta-therapeutic dialogue in terms of indicating positive relationships between resource activation, as a conceptually similar construct, and therapeutic outcomes. However, these studies are less helpful in describing how therapists might actually carry out resource activation or the related elements of meta-therapeutic dialogue.

Solution-focused brief therapy (SFBT) aims to facilitate patients to find exceptions to their difficulties and then find potential solutions which can be implemented without focusing on the cause of the problem (Molnar & de Shazer, 1987). The therapist is conceptualized as facilitating

expression of the client's own expertise regarding what might be helpful for them. The therapist uses solution-focused questions (SFQs) to guide clients to identify and realize their strengths and resources rather than focus on their difficulties and deficits. For example, the patient is encouraged to think of what has worked in the past and changes which they have already made in order to identify potential solutions and to plan how they can integrate solutions into their everyday lives. Thus, "the patients' individual strengths are a key resource that can be drawn upon both to achieve the aims of an intervention and to guide the intervention itself" (Priebe et al., 2014, p.258). Collaboration and the therapeutic alliance are considered especially important when co-constructing therapeutic goals and solutions with clients (Beyebach, 2014). The therapist also uses scaling questions to help them and the client identify and reinforce therapeutically relevant changes.

SFBT can similarly be seen to intersect with the resource activation approaches and meta-therapeutic dialogue on the grounds that there is an emphasis on activating the client's existing resources and co-constructing therapeutic goals and possible solutions. In this sense, both SFBT and pluralistic therapy can be seen to utilize a "problem management/opportunity development" process which also underpins CBT and skilled helper (e.g. Egan, 2009) models (Vermes, 2017, p.46). However, SFBT has been conceptually and observationally distinguished from other problem-solving approaches, such as CBT, on the basis that therapists' formulations in SFBT focus more on the details of *solutions* and focus less on the details of *problems* and problem-solving *per se (*Jordan, Froerer, & Bavelas, 2013). This difference is also informative as to the limitations of the conceptual and practical similarities with meta-therapeutic dialogue about therapeutic methods. Although the use of approach-goals has been advocated in the pluralistic therapy literature (e.g. Cooper, in press; Cooper & McLeod, 2011), pluralistic therapy does not universally advocate being solution-focused over being problem-focused or problem-solving since its technical eclecticism allows that different approaches can be helpful at different times for different clients (Cooper, 2016). Furthermore, pluralistic therapy advocates a *collaborative* technical eclecticism by promoting the co-construction by clients and therapists (i.e. through meta-therapeutic dialogue) of the therapeutic methods used to achieve the therapeutic goals. In contrast, in SFBT there is a co-construction of *therapeutic*

solutions, but not of the *therapeutic methods* used to achieve this. Thus, solution-focused techniques such as SFQs are more likely to be used much more frequently in SFBT than in pluralistic therapy. However, there is still conceivably some conceptual and practical overlap due to the stated importance of the therapeutic alliance in SFBT (e.g. Beyebach, 2014) as well as in pluralistic therapy in the form of meta-therapeutic dialogue. Thus it seems probable that any instances of alliance-focused interactions in SFBT should still appear very similar to meta-therapeutic dialogue in practice.

From the discussion above, it is apparent that there is substantial conceptual overlap between resource-oriented approaches and meta-therapeutic dialogue. We might expect this overlap to be particularly noticeable when issues pertaining to the working alliance, such as goals, methods, solutions and client feedback, are being discussed. Conducting discovery-oriented observational research on how meta-therapeutic dialogue regarding methods is implemented in practice should help us further tease apart the practical and conceptual similarities and differences between meta-therapeutic dialogue and resource-oriented approaches.

2.4.2 Indicative observational research on Solution Focused Brief Therapy (SFBT)

SFBT has been evidenced as an effective treatment for a wide variety of behavioural and psychological outcomes (Gingerich & Peterson, 2013). Beyebach (2014) reports how several process-outcome studies have linked specific practices, including "negotiating goals, discussing pre-treatment changes, seeking and amplifying the details of improvements, giving clients credit for their improvements, continually scaling clients' progress and avoiding conflictive interactions" to therapeutic outcomes (p.62). For example, de la Peña et al. (2012) used the *Relational Communication Control Coding Scheme* (RCCCS, Ericson & Rogers, 1973) and found that competitive and conflictive interactions are associated with poor therapeutic alliances. In demonstrating the benefits of holding for explicit and collaborative discussions regarding therapeutic progress and what the client finds therapeutically helpful, the existing process evidence for SFBT supports the adoption of meta-therapeutic dialogue as defined in the pluralistic literature. However, Beyebach (2014) notes several studies contradicting the expectation in the SFBT literature that questions with

solution-focused presuppositions will increase the likelihood of clients giving solution-focused answers. Stokoe and Sikveland's (2016) Conversation Analysis of mediators' solution-focused questions sheds some light on the possible interactional complexities occurring in relation to these questions. They found that clients commonly resisted the presuppositions of such questions and reverted to complaining. Feo (2012) also reports Conversation Analysis findings wherein callers to a men's helpline resisted counsellors' future-oriented, problem-solving questions by moving back to a troubles-telling focus. These findings show the need for a more inductive observational investigation of local, interactional contexts to objectively interrogate expectations that particular solution-focused interventions will lead to a set of predicted outcomes.

On the basis of their systematic review of research on SFBT processes, Franklin et al. (2017) also recommend a more thorough, observational analysis of the language that therapists actually use in implementing SFBT interventions. Indeed, within the SFBT literature, there is a research stream utilizing a qualitative method called *microanalysis*, which aims to closely examine the "moment-by-moment communicative actions of the therapist" in a discovery-oriented manner (Tomori & Bavelas, 2007, p.25; cf. also McGee, Vento & Bavelas, 2005). This method involves both an action-oriented treatment of language (e.g. Tomori & Bavelas, 2007) wherein participants' talk is parsed or coded in terms of speech acts like questions and formulations and, also, a more evaluative treatment (e.g. Jordan, Froerer & Bavelas, 2013), wherein talk is coded according to the researchers' interests; for example, whether therapists' used positive or negative language in responding to clients' just-prior talk. However, both types of treatment result in categories and codes, which can be considered highly-simplified abstractions from the actual complexity of participants' moment-by-moment interactions. For example, Jordan, Froerer and Bavelas (2013) admit how some utterances could be considered to have both positive and negative aspects using their codes. This admittance shows the need to analyse interactions in ways that are more sensitive to the context in which they are produced, including evidence as to how participants themselves are treating the utterances.

There have been some other uses of the microanalysis method whose findings admit more interactional complexity. For example, Sánchez-Prada and Beyebach (2014) found a multitudinous

range of therapists' solution-focused responses to client reports of "No improvement" and concluded that the literature-based recommendation to *deconstruct* such client reports is an interactionally complex process which defies abstraction into a step-by-step model. Tom Strong and others (e.g. Strong, Pyle & Sutherland, 2009; Strong & Pyle, 2009; Strong & Pyle, 2012) have also produced a series of CA-informed studies, which emphasize the importance of the apparently "messy", tentative, conversationally-hardworking, procedural side to implementing solution-focused interventions. They argue that this implicit, procedural aspect to implementation is essential for developing collaboration when working in a solution-focused manner with clients. However, these authors also acknowledge that their CA studies are preliminary and indicative and that systematic CA research is required to more exhaustively describe how therapists implement particular solution-focused interventions.

2.4.3 Indicative observational research on Resource Activation

As advocated by Flückiger et al. (2016), there is a need to focus on *how* therapeutic approaches are implemented rather than solely macro-level comparisons of *what* approaches are effective. To this end, Flückiger et al. (2009) used the observational coding system, *Resource-Oriented Microprocess Analysis* (ROMA), while investigating whether priming therapists to focus on the clients' strengths influenced therapeutic outcomes. Therapists' use of resource-activating interventions was then measured using observation by trained raters of three sessions from each therapeutic dyad as well as therapist and client self-reports. Both the observational and the self-report data indicated that the priming intervention for therapists did increase their use of resource-activating interventions, which in turn was related to better therapeutic outcomes, such as clients' self-reported self-esteem, mastery and clarification experiences. However, Flückiger et al. (2014) subsequently reported findings inconsistent with these previous studies, namely, therapists' resource-activating interventions of personal goals and positive reinterpretations were *negatively* related to treatment outcome for clients diagnosed with GAD.

This inconsistency shown up by the Flückiger et al. (2014) study shows the need to pay more attention to the nuances of the interactional context in which therapists make resource-activating interventions. For example, clients' positive re-interpretations might also represent instances of disagreement and disaffiliation between clients and therapists and thus indicate a therapeutic rupture (Muntigl & Horvath, 2014). Furthermore, CA studies have demonstrated how therapists' resource-oriented interventions, such as optimistic questions (MacMartin, 2008) and positive feedback (Weiste, 2017) are frequently resisted by clients. Weiste further demonstrates how such interventions can be more interactionally successful if therapists first prepare the ground and attune their talk to the client's emotional state. These CA findings indicate the complexity involved in implementing macro-level concepts like resource activation, or the equivalent action of integrating clients' existing resources during meta-therapeutic dialogue with respect to methods. Thus, as with the other conceptual areas discussed, there is a need for inductive observational research extending beyond the use of pre-existing coding systems.

2.5 Existing conceptualizations of dialogue

2.5.1 Conceptual overview

Papayianni and Cooper (2017) conceptualize meta-therapeutic dialogue as comprising explicit verbal communication between therapists and clients regarding therapeutic goals and methods. Cooper and McLeod (2011) further refer to the occurrence of dialogue between the therapist and client as a preferable basis for discussing therapeutic goals and methods. Following Seikkula and Trimble (2005), Cooper and McLeod (2011) conceptualize a dialogical interaction as a fundamentally respectful encounter in which "each voice…represents a valuable resource" (p.39). Thus, dialogical – as opposed to monological – interactions might involve the therapist presenting ideas as possibilities, in a tentative fashion, with space and encouragement for the client to disagree or add details or suggestions (e.g. McLeod & Cooper, 2012). Dialogical ways of talking are supposed to embrace and explore the possibilities of multiple understandings, both within, and between,

participants (Cooper & McLeod, 2011). Other authors emphasize how dialogical talk facilitates a sense of mutuality and partnership between participants (Seikkula & Olson, 2003), while still others emphasize the *co-production* or "collaborative creation" (De Jong, Bavelas & Korman, 2013, p.17) of new inter-subjective meanings during dialogue, which neither partner would have been able to reach alone or if they had talked in a monological style (Beyebach, 2014; De Jong, Bavelas & Korman, 2013; Seikkula & Olson, 2003; Strong, Pyle & Sutherland, 2009).

2.5.2 Indicative observational research

De Jong, Bavelas and Korman (2013) note how the concept of dialogue or co-construction has remained more theoretical in the therapeutic literature, as opposed to being rigorously practically defined. They illustrate how the microanalysis method (e.g. McGee, Vento & Bavelas, 2005) has been used to investigate observable details of how dialogue is practically accomplished in therapy sessions. They focus specifically on how therapists' questions, formulations, lexical choices and *grounding* (i.e. how they acknowledge the client's response) all contribute to the co-construction of the therapeutic task of agenda-setting. However, this coding of actions without due consideration for their context is subject to the same criticisms as described in Section 2.4.2. Furthermore, the authors assume that *all* instances of the therapist's construction of therapeutic task (e.g. the use of formulations which omit or preserve some of the client's words, according to the therapist's approach) count as "*co*"*-construction* of the task. There is a conceptual issue here as to exactly what counts as "*co*"*-construction* of therapeutic tasks. For example, a reasonable alternative interpretation is that the therapist's formulations are implicitly constructing the tasks, but not in a way that is explicitly open to discussion in a *cooperative* and mutual manner by the client. In contrast, Strong and Sutherland (2007) use observational data to illustrate a conversational ethics which tends towards more explicit co-management and negotiation of descriptive language and styles, to arrive at a mutually acceptable, "shared language of intentions" (p.97). They furthermore advocate that therapists should engage with the client's descriptive language and views, and welcome and encourage corrections or additions from the client, both before and as part of

"offering their own professional conclusions" (p.100). They also illustrate how the therapist can downgrade their expertise and affirm clients "as competent and credible tellers of their experiences and identities" (p.100). As such, Strong and Sutherland advance an illustration of dialogue in which the therapist is more explicitly active in facilitating the client to participate in co-construction. These differing conceptions of dialogue, based on observational data, will be informative for the current project's investigation of meta-therapeutic dialogue with respect to methods.

2.6 Discussion

This literature review has shown that meta-therapeutic dialogue regarding therapeutic methods involves substantial conceptual intersection with several existing therapeutic concepts and approaches, including responsiveness, meta-communication, collaboration, working alliance, negotiation, therapy personalization and elicitation of client preferences, shared decision-making and resource-oriented and dialogical perspectives. This demonstration further supports Coulter's (2017) observation that ostensibly distinct terms such as SDM and personalization, comprise highly similar aims and practices.

2.6.1 Conceptual distinctions between meta-therapeutic dialogue and related approaches

The current review of conceptually-related areas has additionally highlighted some conceptual distinctions which are particularly useful in working towards more clearly theoretically and practically specifying meta-therapeutic dialogue.

We have explored the substantial areas of conceptual overlap between meta-therapeutic dialogue pluralistic therapy and SFBT, such that there is a clear need to more clearly delineate the conceptual and practical distinctiveness of meta-therapeutic dialogue. For example, it should be the technical eclecticism of pluralistic therapy which distinguishes meta-therapeutic dialogue from alliance-focused talk and solution-focused talk more generally. This is since meta-therapeutic dialogue also has the potential to discuss whether and how to helpfully implement therapeutic activities from a wide range of approaches. As discussed, there is a need to illustrate and further

specify how this occurs in concrete practice. McLeod and Cooper (2012) mention "structured problem-solving" as one common therapeutic method which might be used in pluralistic therapy, but the question arises as to whether this is just one of many possible methods or whether it also forms the backbone/basis of meta-therapeutic dialogue – and thereby pluralistic therapy – as well. The evidence for this possibility will be discussed further in Chapter Five.

This review has also highlighted existing interactional specifications of dialogue as the *co-construction* of therapeutic activities. However, we have also noted how, in one sense, all activities are co-constructed by participants, even if this is sometimes more implicit. This issue regarding how to conceptualize co-construction builds on observational findings from research on collaboration, including how ostensibly collaborative sequences of interaction may be more therapist led than they initially appear (Ekberg & LeCouteur, 2014a) and the distinction between mere agreement versus substantial client validation of the therapist's interventions (Eubanks-Carter, Muran & Safran, 2014). In one sense, sequences being more therapist-led and the client merely agreeing and the client substantially validating can *all* be considered co-constructed, since both participants are involved to one degree or another. However, if we are to take co-construction to simply mean *any involvement at all*, then the term becomes quite vacuous and far removed from the original conceptual relationship with dialogue. As discussed in this review, Strong and Sutherland (2007) suggest a conceptualization in which the therapist moves to be as explicit as possible in inviting the client to participate and in affirming client expertise. As noted, there is need to interactionally specify how this might be done in concrete practice and to investigate how therapists and clients might deal with any interactional dilemmas arising, such as managing clients' non-uptake of dialogical invitations (cf. Section 2.6.4 below).

We have discussed the tension between instances of non-collaborative/monological personalization (e.g. the therapist consistently and immediately ceding to client preferences) and more collaborative, dialogical forms of personalization. This tension has been anticipated by Cooper and McLeod, but the ongoing development of personalization tools (e.g. Cooper & Norcross, 2016)

does call for some conceptual and practical clarification as to how these can be combined with the desirability of meta-therapeutic talk also being dialogic.

2.6.2 How related approaches practically inform meta-therapeutic dialogue about methods

The current review has highlighted how related approaches can practically inform how the pluralistic therapist can carry out meta-therapeutic dialogue regarding therapeutic methods. For example, the need to acknowledge negotiation and rupture repair as integral – but also more challenging – aspects of collaborative processes (Safran & Muran, 2006). We have also reviewed how Land, Parry and Seymour (2017) have used existing CA on shared decision-making to compile descriptors of relevant actions around the commitment point. In particular, the descriptors of *broaching* and *putting forward a course of action* seem ostensibly relevant to how clients and therapists might begin to carry out meta-therapeutic dialogue with respect to therapeutic methods.

This review has also noted the potential of informal opportunities for identifying client preferences, views and resources which might otherwise remain unexplored in more formal opportunities using decision aids. We have reviewed some strategies from existing resource-oriented approaches, which seem highly relevant for tapping into existing client resources and ideas regarding what might be therapeutically helpful; for instance, the use of *solution-focused questions* to elicit client resources and the use of *resource-activation* to remind the client of their resources. Furthermore, observational research on collaboration proffers the proximate zone of therapeutic development construct (Leiman & Stiles, 2001) as a means of guiding when and how to invite the client to participate in meta-therapeutic talk. However, there is still a need for observational research regarding how informal, meta-therapeutic opportunities for discussing clients' preferences and resources in relation to therapeutic methods in the specific context of pluralistic therapy.

2.6.3 Relationship of current review findings with research on collaborative goal formation

There is conceptual overlap between meta-therapeutic talk regarding therapeutic methods and practice-based research on goal-setting, since both are described as collaborative ventures which

involve shared decision-making or meta-therapeutic processes (e.g. Law & Jacob, 2013; Cooper et al., 2016). For example, in their practice-focused review, Law and Jacob (2013) note how goal-setting can facilitate shared decision-making processes by leading to explicit expression and agreement regarding the therapeutic work to be done and so contribute towards improved working alliance, outcomes and service user satisfaction. Furthermore, Cooper and McLeod (2011) note how the terms *goals* and *methods* should not be taken too literally and that the terms should be taken to loosely and widely refer to what clients want (goals) and what they might do to make this happen (methods). As such, it stands to reason that what we know about meta-therapeutic practice around goals can apply to methods and *vice versa*.

A current, predominant focus in the goal-setting research is on using goals to evaluate progress through the formation of quantitative, goal-based outcomes (GBOs). This research comprises quantitative outcome studies (e.g. Rupani et al., 2014), qualitative self-report research on users' experiences of GBOs (e.g. Bromley & Westwood, 2013) and thematic analysis of the content of goals (e.g. Jacob et al., 2016). With more relevance for the current research project, there is additionally a developing body of practice-focused research on how goal-setting is actually, concretely done and how this can be done more or less collaboratively. For example, Crits-Christoph et al. (2006) demonstrated the therapeutic effectiveness of an alliance-focused training, which required therapists to establish explicit goals and to evaluate and fine-tune agreement regarding these in every subsequent session. Based on their respective meta-analyses of goal-setting in therapy sessions, Tyron and Winogrand (2011) recommended that therapists should respectfully request clients' feedback, insights and elaborations, while DeFife and Hilsenroth (2011) suggested that goal-setting might be initiated by therapist moves to clarify the concerns which led clients to seek therapy in the first place. Thus far, these practice-focused research and recommendations regarding collaborative goal-setting cohere with the findings from the current review with regard to therapeutic methods – namely the need to *explicitly* establish and agree on goals/methods and to do this on an ongoing basis, in a respectful, dialogical manner.

Oddli et al.'s (2014) findings from their discovery-oriented observational study introduce some complexity and ambiguity into the body of findings regarding meta-therapeutic discussions about goals. Similarly to the Oddli and Rønnestad (2012) study relating to therapeutic methods, Oddli et al. (2014) found that, across nine integrative therapist-client pairs, there was a lack of explicit agreement regarding goals between clients and therapists. This raises the possibility that recommendations to be explicit when goal-setting are not often practically implemented by therapists. Instead, Oddli et al. found that therapists engaged in more implicit goal-oriented activities, such as showing awareness of the client's potential ambivalence to change. In a further twist of complexity, Oddli et al. found that ostensibly future-focused strategies, such as eliciting expectations for change were frequently followed by further elaboration of the client's presenting problem, rather than leading on to more explicit goal-setting sequences. This led Oddli et al. to suggest that the projects of clarifying therapeutic goals and methods may be practically intertwined rather than discrete and linear activities as they have been conceptualized to date. This possibility will need to be addressed in the current project, alongside the possibility that there will be little explicit meta-therapeutic talk in the data for the current project.

2.6.4 Transferability and anticipated obstacles in implementing meta-therapeutic dialogue

The discussions in the current review raise the question as to how transferrable findings from other healthcare contexts are to counselling and psychotherapeutic contexts. For example, research has indicated that instances of explicit collaboration and SDM may be more implicit or less frequent in therapeutic contexts compared to other healthcare and more traditional, physically-focused medical contexts (Gibson et al., submitted; Salyers et al., 2012; Oddli & Rønnestad, 2012). Our discussion of the literature has also highlighted the important finding that patients can resist decisional responsibility, raising a consideration as to whether concepts such as shared decision-making are in fact incongruent with pre-existing social realities, such as professional asymmetries (e.g. Thompson, 2013). There is an ongoing need for more observational research on SDM in therapeutic and

counselling settings, including the current research project, in order to establish the extent to which these issues are relevant in counselling and psychotherapy settings.

Thompson's (2013) finding regarding clients' resistance to decisional responsibility has also been supported by findings from client interviews which indicate that clients can be reluctant to participate in collaborative processes due to factors such as deference to the therapist and perceived inadequacy (Eubanks-Carter, Muran, & Safran, 2014; Eliacin et al., 2015; Gibson, 2016; Hamann et al., 2016; Regan & Hill, 1992; Rennie, 1994). However, clients' non-participation in meta-therapeutic opportunities can result in the loss of their expertise in effectively determining the therapeutic direction (Cooper & McLeod, 2011). Client expertise can be conceptualized as their subjective and cultural knowledge of what feels appropriate at this time, as well as autobiographical knowledge of what has helped them historically (McLeod, 2013). Such findings speak to an underlying tension in meta-therapeutic dialogue and conceptually-related areas: how might it be possible to bring *both* client and therapist expertise into play?

The developers of pluralistic therapy, based on their own clinical experience, have duly noted that client reluctance to participate in meta-therapeutic dialogue is a practical obstacle which therapists may also have to negotiate (Cooper & McLeod, 2011; Cooper et al., 2016; McLeod & Cooper, 2012). The authors anticipate that clients may be tentative and need help in expressing and developing their ideas and preferences and that, ideally, the therapist will find a balance between encouraging clients to do so by showing curiosity while still avoiding putting clients on the spot. The authors further note that one paradox of working pluralistically is that sometimes a less dialogical and less collaborative approach to selecting therapeutic methods will be required, for example, if the client strongly indicates that the therapist's sole input and expertise in selecting therapeutic methods would be helpful at a particular point. This point is further developed by Priebe (2017) who describes how patients' preferences for being involved in decision-making about mental health treatments "differ associated with their personality, background and experiences, and may vary even for the same patient depending on the given health problem, the context, the specific content of the consultation, and the mood on the day" (p. 157). Cooper and McLeod (2011) recommend

that, even in such instances, the pluralistic therapist should still periodically check in case the client can now collaboratively contribute. In cases of client reluctance, it may also be that the client may just need some help or time to formulate their preferences and knowledge. So, even in cases where the client seems reluctant to participate, the pluralistic therapist is still required to periodically attempt collaborative conversations with the client about therapeutic methods.

The current research project, focusing on meta-therapeutic dialogue with respect to therapeutic methods, should contribute to these discussions regarding how therapists actually work to encourage the client's participation and, indeed, regarding whether it is appropriate and realistic to expect such participation in therapeutic contexts in the first place.

2.6.5 Limitations

One of the main limitations of this study is its networked and unsystematic nature. This means that its findings can be considered, at best, indicative and preliminary. Findings from a systematic review would be more definite and comprehensive in coming to conclusions regarding the state of observational research on processes related to meta-therapeutic dialogue.

The current review focuses predominantly on observational research and, as such, illustrates some aspects of the therapeutic process. This focus leaves un-investigated the relationship between these aspects of process and therapeutic outcomes. Furthermore, this review has not considered in detail whether and how these illustrations might relate to existing research regarding participants' self-reported experiences of meta-therapeutic and related processes. Most probably the self-report research would under-specify the nuances of the actual process, but to what extent and at what points under-specification occurs are valid empirical questions, which, if investigated, could inform future study designs.

2.6.6 Conclusion

This review has compiled some evidence as to the consistent need for specifying the concrete practice of meta-therapeutic dialogue and related processes. Furthermore, it has shown how

discovery-oriented investigations such as CA studies can contribute towards fulfilling this need, namely by highlighting the moment-by-moment complexity of meta-therapeutic dialogue and related processes. For example, this review has reported on how apparently minor interactional details, such as choice of pronoun, can substantially impact constraints facing the client when responding (e.g. Landmark, Svennevig & Gulbrandsen, 2016; Thompson 2013). In addition, a recurring theme pertains to differences arising between the initial, preliminary – or what we might conceptualize as the *interaction-far* – appearance of ostensibly relevant instances of collaborative or mutual actions and the ambiguities arising with a more in-depth, *interaction-near* focus on the concrete details participants treat as important during the interaction (e.g. Ekberg & LeCouteur, 2014a; Eubanks-Carter, Muran & Safran, 2014; Land, Parry & Seymour, 2017; Oddli & Rønnestad, 2012). As such, we can expect the findings from the current research to indicate the multi-faceted and dynamic nature of instances of meta-therapeutic dialogue with respect to therapeutic methods.

Chapter 3: Methodology

3.1 Conversation Analysis

Conversation analysis (CA) is a qualitative approach to the study of how people verbally and non-verbally interact in naturally-occurring situations in social life (Sidnell & Stivers, 2013). Its basic goal is to identify the social actions that participants carry out and then the particular interactional practices or features they utilize to accomplish these actions (Sidnell, 2013). Appendix A contains a glossary of the CA technical terms used frequently in this thesis.

3.1.1 Brief intellectual history and epistemology

Conversation Analysis was developed in the late 1960's and early 1970's by Harvey Sacks, Emanuel Schegloff and Gail Jefferson in the Sociology Department of the University of California, Los Angeles (Hutchby & Wooffitt, 2008). The method was devised as one of a number of alternative research methods in sociology. These alternative methods contrasted with the predominant focus at the time on macro-level social functions and structures and a concomitant de-emphasis of the human actor as just "a passive bearer of sociological and psychological attributes" (Heritage, 1984, p.2). In particular, Sacks and the others developed Conversation Analysis while endeavouring to apply Harold Garfinkel's ethnomethodological perspective to talk (Heritage, 1984). Garfinkel and others, such as Erving Goffman, had launched a sustained critique of the mainstream sociological perspective. Their main critical argument was that this mainstream approach was needlessly reductionistic and utterly neglected a rich source of sociological information, namely detailed and careful observation of how ordinary members of society actually constructed and assumed intelligibility and social order as they went about their daily lives (Heritage, 1984). Garfinkel labelled methods which prioritized this latter research aim as *ethnomethodological*. Goffman's sociological research also often focused on the organization of everyday life, which he termed *interaction order* (Drew & Wootton, 1988).

In developing the ethnomethodological approach, Garfinkel was influenced by phenomenological approaches, since they prioritize careful analysis of the phenomenon as it is in itself rather than attempting to theoretically describe the phenomenon *a priori*. In particular, he drew upon Schutz's (1967) *phenomenology of sociology* (Heritage, 1984). For example, Schutz identified *Verstehende* processes as central to how the world is meaningfully interpreted and treated as intelligible by ordinary members of society. Furthermore, Schutz's resolution of the problem of inter-subjectivity in social settings coheres with the ethnomethodological handling of this problem – which is to treat it as a practical one which is routinely and variously resolved by members of society as and when it arises (Heritage, 1984). Schutz also offered insights regarding how members can sustain such a practical treatment of the problem of inter-subjectivity. Firstly, they assume, until proved otherwise, that their experiences of the world are sufficiently similar for all practical purposes (Heritage, 1984). Secondly, they reflexively treat their inferences about other members' actions as contingent and revisable in the face of new information about how actions are unfolding. Schutz's phenomenological insights regarding how members construct and assume the intelligibility of social life and order have come to form a key principle of ethnomethodological approaches, including Conversation Analysis.

The ethnomethodological emphasis on the local, moment-by-moment, reflexive determination of meaning in particular social situations shares some similarities with social constructionist paradigms, namely that meaning and intelligibility are always situationally contingent (e.g. Edwards & Potter, 1992). Garfinkel's development of a reflexive stance on meaning and action is motivated by the particular conclusion that predetermined norms and/or general rules are not sufficient for explaining social actions, since there is evidence that members reflexively use such rules but that their actions are not straightforwardly determined by them (Heritage, 1984). Another of Garfinkel's key original insights in developing ethnomethodological approaches pertains to his in-depth exploration of how members can treat other members as accountable or responsible for their actions, particularly if these actions are unusual or unacceptable (Heritage, 1984). In a series of *breaching experiments*, Garfinkel highlighted how members always displayed the assumption that

other members' unusual or unacceptable actions were intelligible even if they did not currently have access to what the grounds for this intelligibility might be. Furthermore, Garfinkel identified a moral layer to this ubiquitous assumption of accountability, such that if members attempted to avoid explaining their unusual or unacceptable actions, then they would very rapidly be treated in a hostile manner by their interlocutors (Heritage, 1984).

In this intellectual milieu of Goffman's emphasis on the interaction order, Garfinkel's ethnomethodological perspective and its phenomenological and social constructionist relations, Sacks, Schegloff and Jefferson set out to contribute through careful observation of how ordinary members of society assumed and constructed social order in their everyday lives. Recordings of telephone calls seemed like a convenient starting point due to the potential for capturing sequences of everyday interactions in minute detail (Sacks, 1995). Recordings also enabled the researcher to re-play this representation of the interactions, in order to check and refine their observations. In using recordings for this purpose, they developed some distinctive methods for studying naturally occurring interactions, which they called Conversation Analysis. These methods will be outlined in some detail in the next section. It is these methods which distinguishes Conversation Analysis from other ethnomethodological approaches as opposed to any overarching differences in principles.

3.1.2 Methodological overview

3.1.2.1 Data and transcription CA fundamentally aims to elucidate participants' *culturally-shared* practices for producing and interpreting social actions (Pomerantz, 2012). Participants' retrospective reports of their goals and motives are actually considered unnecessary – and even helpful – for this achieving this aim, especially since such participants may not be able to remember or articulate their actions at the level of interactional detail required (Hepburn, Wilkinson & Butler, 2014; Pomerantz, 2012) and, furthermore, some of these practice may operate below conscious awareness (Sidnell, 2013). Thus, following ethnomethodological principles, CA research utilizes sustained and careful observation of how members of a society actually go about doing this in their everyday lives. From

this observational data, we can then elucidate members' own analyses of what they are doing while they are doing it (Sidnell, 2013).

CA research focuses on naturally-occurring interactions, since it is impossible to determine *a priori* which features of the context might be relevant in order to elucidate particular practices utilized by participants (Mondada, as cited in Kendrick, 2017). It has long been acknowledged in CA research that recordings of interactions allow a focus on detail which may not be otherwise remembered or noticed if the interaction is just observed as a one-off event (Sacks, 1995). However the proper data of CA is the interaction itself. Extracts of interest from recordings are transcribed in order to systematically represent and examine features of interest. However, again, it is acknowledged that transcripts are only ever finite and fallible representations of the actual data i.e. the interactions that occurred between participants (Hepburn & Bolden, 2013).

Conversation Analysts transcribe recordings of the interactional data to represent *how* the speakers produced talk, as well as the content of the talk. This focus on the production of talk includes indicating pauses between conversational turns, showing overlap of speaker's turns and how speakers design or concretely produce their actions, in terms of repairs, and relative speed, pitch, volume and gestures (Hepburn & Bolden, 2013; Jefferson, 2004). Variations in these features, among others, are the basic building blocks of the interactional practices by which participants accomplish social actions. Appendix B contains a key to the Jefferson Transcription Symbols used in this thesis.

3.1.2.2 Types of analytic evidence There are several sources of evidence available to Conversation Analysts when working to elucidate what actions participants are accomplishing in their talk and non-verbal interactions and what interactional practices they are utilizing to do so. These forms of evidence have been developed as analytic resources by previous CA studies and research projects (Sidnell, 2013).

As discussed above, all evidence must be grounded in what participants demonstrably do and treat as important and relevant in the interaction. Most CA evidence is based on descriptions of

particular instances of what participants observably do or display. This includes the next-turn proof procedure, whereby how the current speaker responds to a previous speaker's turn shows the current speaker's interpretation of what kind of action the previous speaker was implementing (Sacks, Schegloff & Jefferson, 1974). Furthermore, participants sometimes explicitly refer to norms or expectations relevant in the current interaction (e.g. "why haven't you answered me?"), which is also used by Conversation Analysts as evidence of what participants themselves are treating as important in this particular interactional context (Sidnell, 2013). The way in which participants take conversational turns (e.g. by overlapping with another speaker) or do not take turns, resulting in pauses, can also be used as evidence as to how participants are working to accomplish particular actions, such as pursuing an answer to a question they have asked previously. Further evidence as to what participants are treating as important in the interaction can stem from explanations or accounts which they give for their actions or which other participants request. Such explanations or requests for explanations display participants' normative expectations regarding the kinds of conduct that they are or others should be engaging in (Antaki, 1994). As a final example of evidence which is demonstrable from particular cases of interaction, the manner in which speakers repair or re-do aspects of their turns-at-talk (i.e. before these turns are hearably complete) also shows what kinds of issues they are treating as relevant in performing a particular action in a particular context for a particular recipient (Drew, Drew, Walker & Ogden, 2013; Raymond, & Heritage, 2013; Silverman & Peräkylä, 1990). Indeed, the manner in which a speaker designs their turn can hearably project a particular kind of response from the recipient (Silverman & Peräkylä, 1990).

Conversation Analysts have also made use of comparative evidence derived from comparing one or more instances of an action or a practice. For example, Lindström and Sorjonen (2013) discuss how comparing various practices for accomplishing an action can create some analytic leverage, for example, in terms of allowing a series of practices to be placed along a continuum of being more or less affiliative. Indeed, over the last several years, Heritage (2013) has developed a well-regarded epistemic analysis of interactions utilizing just such a comparative approach alongside continuums, which rank cases in terms of, among other things, how much participants assert

epistemic primacy over the content of their talk. Drew (2003) and Curl and Drew (2008) further provide comparative analyses of how similar actions (e.g. requests) can be differently carried out across institutional and everyday contexts and put forward the argument that such comparative analyses facilitate valuable and interlocking insights regarding what participants are treating as important across these contexts. Kendrick (2017) also generally characterizes CA as closely describing single cases before moving on to inductively produce valid generalizations. However, there is a need for analytic caution since such comparative evidence does not replace the requirement for demonstrable evidence stemming from within each particular case regarding how participants are treating a particular practice or action. As observed by Sidnell (2013), comparative evidence does not provide evidence for what is happening in particular cases, but it does provide some inductive grounds for claiming that features, which re-occur across cases, might be generic of a particular interactional practice. However, for any CA claim made at this generic, comparative, inductive level, "the analyst always remains accountable to each individual case and its particularities" (Sidnell, 2013, p.78). This means that generic, context-independent claims made about actions and practices are always subject to revision or adjustment if new, contradictory individual cases come to light.

As a result of this combination of careful description of particular stretches of interaction, alongside more comparative, inductive analyses, Sidnell (2013) notes how CA findings are often "cumulative" and "mutually reinforcing" (p.95). For example, Jefferson (1984) identified a "one second maximum" for responses after which time participants demonstrably treated the pause as indicating some kind of problem in progressing the interaction. Kendrick and Torreira (2015) have subsequently further interrogated this analysis and have found that Jefferson's "maximum" roughly holds, but with some variations and qualifications depending on whether such pauses are conceptualized or coded as being part of the turn design. In addition, in developing this analysis, Kendrick and Torreira (2015) further drew upon, and subsequently elaborated, Pomerantz's (1984b) paper on preferred and dispreferred turn shapes. This cumulative character of CA findings has implications for the current project since it can be anticipated that its findings will draw upon

previous CA findings for the purposes of evidencing and contextualizing them, as well as potentially adding to the existing body of findings.

Recent thinking around CA methods has highlighted some problematic issues in terms of how Conversation Analysts ascribe actions or action-labels to particular interactions. For example, Hofstetter (2016) highlights instances in which ascribing a particular action-label ('request') to a particular stretch of interactions may not adequately describe the fluidity and flexibility with which participants treat their own actions and response possibilities. Here, Hofstetter has built on Sidnell and Enfeld's (2014) appeal for analysts to interrogate assumptions that what participants treat as important is comprehensively described by particular action-labels which just happen to be available in the analyst's language. Levinson (2013) also highlighted how the analyst's pinning of an action-label upon a stretch of interactions can be arbitrary in terms of assuming that participants are just accomplishing one unambiguous action – as opposed to multiple, possible actions – at any particular point. The suggestion for Conversation Analysts, going forward, is that they take care to parse any action-labels or other such glosses in terms of what participants are demonstrably doing and displaying. The current project was guided by these recent debates and this analytic guidance arising from them.

3.1.2.3 Validity The main source of validity for CA findings is *apparent validity* (Kirk & Miller, 1986, as cited in Peräkylä, 2004b). This derives from how the evidence for these findings should be demonstrable and apparent to readers in the accompanying data extracts. Thus, the validity of CA claims should be immediately apparent to readers, once they have read through the analytic commentary and extracts. In attempting to achieve apparent validity, I am also enabling readers to judge for themselves how much my analysis fulfils the CA/ethnomethodological principle of elucidating what is demonstrably important to the participants in the interaction and not imposing my categories upon their interactions.

The validity of the CA findings in this project has also been interrogated by CA researchers at numerous data sessions and conference presentations in which I played the recordings

accompanying the transcripts. The discussions I had with researchers at these events helped to ensure I was indeed using publicly-available features of the interaction to evidence my claims. In my analytic commentary, I occasionally include references to interactional phenomena or practices described in previous CA research. I provide these references so that readers can follow the trail of established evidence and knowledge regarding practices which are similar or related to ones in my data. However, as emphasized by Sidnell (2013), my analytic claims regarding each extract need to be substantially evidenced in themselves using the features of the interaction displayed in this extract.

The generalizability of CA findings to other data collections is determined by sampling considerations (Peräkylä, 2004b). Starting in Section 3.3.4, and throughout this thesis, I will discuss issues around the generalizability of the current findings.

3.1.3 Overview of how CA can be applied in institutional settings

From its earliest stages of development, Conversation Analysis was applied to recordings of interactions in both mundane or everyday interactions and institutional interactions, such as suicide crisis helplines (Sacks, 1995). Institutional interactions tend to be more structurally restricted and asymmetrical in terms of participants' roles and entitlements to talk (Heritage & Clayman, 2011; Drew & Heritage, 1992). However, similarly to our discussion of norms earlier in this chapter, these differences between the structure of mundane and institutional interactions are conceptualized in CA as being due to how participants themselves shape and renew institutional contexts through their actions. Such a conceptualization removes the need for assuming a pre-existing institutional context over and beyond the participants' actions. In the same vein, Conversation Analysts endeavour not to assume *a priori* that institutional interactions are structured differently to mundane ones but instead look to participants' actions in each particular instance to see how they are arranged (Sidnell, 2013). So, for example, a CA study will not start with assumptions of asymmetrical power relations between clients and therapists. However, given data containing some observable asymmetries such as participants publicly orienting to inexpert/expert roles, CA can

explicate how these are dynamically constructed and reconstituted, moment-by-moment, by the participants themselves within their interactions.

Antaki (2011) identifies different ways in which CA can be *applied* to non-mundane institutional interactions. These include his distinction between *institutional applied CA* which seek to research or find out more about how participants interact in institutional ways (e.g. Silverman, 1997) versus *interventionist applied CA* which seek to intervene in the interactions by focusing on a previously identified practical problem and attempting to engineer change grounded in CA findings (e.g. Heritage et al., 2007).

3.2 Application of Conversation Analysis in this project

I will now detail how I will use Conversation Analysis to achieve the aims outlined in Chapter One.

3.2.1 Conducting discovery-oriented investigation while engaging with existing SIKs

The ethnomethodological principles underpinning CA, together with the method's existing, cumulative body of findings, enable discovery-oriented observations of how clients and therapists respond to each other and of what each treats as important in the interaction.

This is possible since CA enables detailed and comprehensive descriptions of interactions in the therapy sessions – without having to utilize exogenous theoretical categories as the evidential basis for identifying and describing participants' interactions. Cantwell and Rae (2015) conceptualized the lack of reliance on clinicians' or researchers' theoretical categories as enabling the descriptions to achieve an *extra-therapeutic perspective* on the interactions. The non-therapeutic interactional features described from this extra-therapeutic perspective can then provide new information for triangulating, critiquing and extending existing therapeutic perspectives on the interaction (Gale, 2000; Madill et al., 2001; Peräkylä & Vehviläinen, 2003; Silverman, 1997; Stiles, 2008; Thompson and McCabe, 2012; Voutilainen & Peräkylä, 2016).

Peräkylä and Vehviläinen (2003) have articulated a very useful conceptual framework for how the extra-therapeutic perspective created by the CA findings can be fruitfully connected with

existing therapeutic perspectives regarding particular instances of therapeutic interactions. They highlight how CA can help to elucidate, elaborate and extend our procedural knowledge of how therapists actually put models of how they should interact with clients into practice. Peräkylä and Vehviläinen conceptualize these idealized models and concepts as practitioners' *stocks of interactional knowledge* (SIKs), which are shared by practitioners and described in existing therapeutic clinical and research literature and training materials. Peräkylä and Vehviläinen clarify that SIKs can specify therapists' concrete actions to a greater or lesser extent and they identify several means by which SIKs can be informed by CA findings, including falsifying and correcting assumptions contained in a SIK, provide more detail for practices described in a SIK, add new understanding of practices described in a SIK or provide descriptions of practices not provided by a highly general or abstract SIK.

Previous CA research on therapeutic interactions has produced findings relevant to a variety of existing SIKs. Such research has been conducted on data from a range of therapeutic approaches, including: emotion-focused therapy (e.g. Muntigl et al., 2013; Sutherland, Peräkylä & Elliott, 2014), existential therapy (e.g. Kondratyuk & Peräkylä, 2011), dialectical behavioural therapy (Jager et al., 2016), cognitive behavioural therapy (e.g. Antaki, & Jahoda, 2010), cognitive therapy (e.g. Weiste & Peräkylä, 2013), child psychoanalytic psychotherapy (e.g. Leudar et al., 2008), psychoanalysis (e.g. Peräkylä, 2005) and narrative and solution-focused therapies (MacMartin, 2008; Strong, Pyle, & Sutherland, 2009). Rae's (2008) study exemplifies how CA can contribute towards extending the existing SIK of *active listening*. He explicated how a previously unnoticed interactional practice, *lexical substitution*, was used by a therapist to accomplish active listening, thereby contributing to SIKs concerning how active listening gets done in concrete situations.

Therapist's interpretations of client's prior talk are another area in which CA researchers have contributed to clarifying and extending existing SIKs. For example, Berceilli et al. (2008) and Voutilainen et al. (2010b) analysed therapists' interpretations into their precise interactional components, focusing in particular on how therapists designed these differently to other talk in which they worked to show understanding of what the client had been saying. In particular, Berceilli

et al. demonstrated how therapists, after interpretations, frequently pursue extended agreement – as opposed to mere confirmation – from clients. Peräkylä and others have also provided comprehensive evidence for a robust *interpretative trajectory*, spanning from how therapists can construct puzzles to prepare the ground for interpretations (Vehviläinen, 2003a) to how clients can subtly resist the import of therapists' interpretations (Peräkylä, 2005) to demonstrating evidence that therapists often take a third interpretative turn after the client had responded to the therapist's first interpretative turn (Peräkylä, 2010). CA researchers have noted how these interactional features of interpretations seem to be highly robust and to occur across different approaches (Peräkylä, 2013; Vehviläinen et al., 2008). However, comparative studies have also highlighted some practices which seem to be highly specific to particular approaches (e.g. Weiste & Peräkylä, 2013), once again demonstrating how CA can help us to clarify SIKs regarding what therapists actually concretely do in order to interact in a therapeutic manner with clients.

Vehviläinen conducted a series of studies on career guidance counselling (e.g. Vehviläinen, 2003b) which are of relevance to the current research project. Her 2003b study focuses on how therapists concretely apply the principle of client self-directedness, particularly when clients ask the counsellor for advice. Her findings indicated at least two ways in which counsellors manage this situation while still orienting to the principle of the client's self-directedness. The first is to answer the question before subsequently sanctioning or indicating the inappropriateness of the question. The second is to first elicit the client's views before then giving some advice in this context. These findings helped to extend existing SIKs concerning how therapists concretely apply the principle of self-directedness.

These examples of how CA can contribute to specifying therapeutic SIKs formed the conceptual roadmap for working towards the aims of the current project. As outlined in Chapters One and Two, the SIKs regarding meta-therapeutic talk in the existing literature are vague. So my basic aim in the current project was to explicate what therapists and clients concretely do in carrying out meta-therapeutic talk regarding methods. A further, more specific aim was to investigate opportunities for *meta-therapeutic dialogue*, as described by SIKs contained in Cooper and McLeod

(2011) and Papayianni and Cooper (2017), among others. Again, these SIKs regarding dialogue are vague and may require the construction of some intermediate SIKs to coherently link them with concrete practice (Peräkylä & Vehviläinen, 2003). For example, Peräkylä (2013) discusses how a broad SIK, such as the working alliance, cannot be fully equated with particular practices as other more specific SIKs might (e.g. scaling questions in solution-focused therapy). SIKs for broad, interactionally vague constructs instead have to accommodate the reality of how these constructs are probably composed of small-scale interactional events between participants (Streeck, 2008 as cited by Peräkylä, 2013).

I therefore expected to have to do some conceptual work in order to link participants' concrete actions in therapy sessions with SIKs in the literature regarding meta-therapeutic dialogue. As we shall see in Chapters Four and Five, part of this missing link I worked to provide consisted of instances in which therapists demonstrably carried out an action which could be considered part of meta-therapeutic dialogue. These instances showed how therapists used SIKs about meta-therapeutic dialogue to concretely structure the immediate, concrete interactions (Leudar et al., 2008).

In the following sections, I will detail some further conceptual and methodological issues which arose during my attempts to use SIKs while conducting a CA study, with the ultimate aim of contributing to reducing the research-practice gap around meta-therapeutic dialogue with respect to methods.

3.2.2 Conceptual issues in relating SIKs and CA findings

As detailed in Section 3.1, CA findings should be demonstrably founded in participants' own treatment of their actions and not in other knowledge domains exogenous to participants' actions. Thus, these findings should consist of non-evaluative descriptions of how clients and therapists concretely interact in the service of therapeutic business. If therapists or clients demonstrably orient to SIKs in the interaction, then such SIKs are an integral element of the findings and the analyst needs to be familiar enough with these SIKs to articulate their relevance for participants in the

interaction (Peräkylä & Vehviläinen, 2003). Vehviläinen et al. (2008) drew a related distinction between *local consequences* (i.e. "what a particular action brings about in its immediate environment") and *therapeutic functions* (i.e. how "a particular action may contribute to, or resist, the overall objectives of a particular kind of psychotherapy") (p.189). The implication of this distinction is that CA alone can articulate the local consequences of an action, but therapeutic SIKs may be needed to articulate its possible therapeutic function. Leudar et al. (2008) furthermore argue that the specific therapeutic import of participants' actions cannot be articulated unless the analyst is adequately familiar with the therapist's therapeutic orientation and the SIKs which they may be drawing upon when interacting with the client.

A thorny analytic issue arises here regarding how to distinguish between instances when participants are demonstrably orienting to the therapeutic functions of their actions and when drawing such therapeutic functions becomes solely a research interest, exogenous to the participants' interests in the interaction. In opposition to Schegloff (1991), Leudar et al. (2008) argue that such a distinction is impossible to uphold and that we will always need to refer to circumstantial SIKs to be fully informed regarding the possible therapeutic import of the therapist's actions. In this thesis, I held the position that we at least need to be conceptually mindful of this distinction when conducting the analysis. If we indiscriminately and unreflectively admit exogenous interests to inform our analysis of what participants are doing, then this detracts from the unique, discovery-oriented, extra-therapeutic perspective CA can offer on how clients and therapists concretely interact (Cantwell & Rae, 2015; Madill, 2015). For example, if we start to describe participants' terms only using terminology from SIKs or if we start to substitute description of participants' actions for evaluation of them using existing SIKs, then we can no longer access the discovery-oriented perspective of CA. Furthermore, such use of SIKs in place of careful description of participants' own displayed interests would fall foul of the usual criticisms of existing observational non-CA research outlined in Chapters One and Two. Of course, Leudar et al. (2008) were not advocating for these uses of SIKs which bypass or eliminate the essence of the CA method. However, my point is that we

are at risk of inadvertently doing so unless we clarify and practice vigilance as to how we are using SIKs in when applying CA to interactions in institutional settings such as therapy.

In what follows, I will outline some stages of the current project in which it seemed particularly necessary to conceptually clarify how I was using SIKs. These stages are data selection, the use of SIKs in the analysis itself and the drawing of clinical implications.

My claim throughout this section is that it is possible to carry out CA of individual extracts separately to the analyst's theoretical and practical motivations, which inform the selection of extracts and the drawing of implications. It might be questioned as to whether my analysis of the individual extracts is being subtly influenced by these other motivations. In response to this potential criticism, I would argue that regardless of any such motivations, the validity of the Conversation Analytic findings should nevertheless be supported by the factors previously discussed in section 3.1.2.3.

3.2.2.1 Data selection Knowledge of relevant therapeutic SIKs is useful for selecting clinically relevant instances of interaction for CA analysis in the first place. For example, in the current study, I initially listened to recordings in order to compile a pool of instances of talk which might be considered meta-therapeutic (cf. Chapter Four). Subsequently, I selected a collection of these instances for an in-depth investigation using CA (cf. Chapters Five through Eight). The initial process of compiling a pool of relevant instances can be considered a form of theoretically-informed selection. In order to operationalize this research focus, I developed a thematic code of *talk about what might be therapeutically helpful* to guide the initial selection (cf. Chapter Four). This code depended on my knowledge of existing SIKs as opposed to what the data showed me participants were doing. As such, this initial data selection process can be considered exogenous to the interests of the participants in my data. *Prima facie*, this puts my initial research focus in conceptual tension with the ethnomethodological principle that CA should focus on explicating the import which participants themselves attribute to their actions as they are carrying them out.

This data selection process can be defended if we draw a distinction between how cases of interest are identified and selected and how these selected cases are subsequently analysed: while the overarching research focus and data selection method might extend beyond participants' endogenous interests in the interaction, the subsequent Conversation Analysis of selected extracts can still focus solely on elucidating these endogenous interests. Indeed, it can be argued that the criteria motivating data selection in any CA study technically extends beyond the endogenous interests of participants in any particular stretch of interaction. Even Schegloff's (1996) endorsement of *unmotivated looking* still relies on the analyst's curiosity and pre-existing research interests as a means for selecting cases. Sidnell (2013) also notes how we can use the results of previous studies to guide what stretches of the current data which we are interested in. Ultimately, there is a distinction between how stretches of talk are initially selected (e.g. using existing SIKs), and the CA investigation proper, which focuses on the details of the selected talk and what participants are treating as important within this selected talk.

3.2.2.2 Use of SIKs during analysis proper While undertaking the actual analysis of extracts, I tried to avoid using terminology from SIKs to describe or otherwise therapeutically gloss or evaluate participants' actions. This was since using therapeutic terms from the outset might detract from the discovery-oriented potential of the analysis to create an extra-therapeutic perspective on the actions (Cantwell & Rae, 2015). My caution here was in part inspired by Levinson's (2013) and Sidnell and Enfield's (2014) appeals to avoid using culturally available action-labels (or in the current case, therapeutic SIKs) as glosses and, instead, to focus on describing what the participants were concretely doing and treating as important. For me, the impetus of these appeals lies in the push to avoid relying on cultural connotations of particular action-labels and to work to get some analytic distance to more clearly elucidate the formerly implicit connotations. I consider Potter and Hepburn's (2010) analysis of laughter in words as *interpolated aspirations* as a model example of such an analytic push.

I also found Vehviläinen et al.'s (2008) distinction, discussed earlier, useful at this stage. It helped me to initially focus just on the *local consequences* of participants' actions. Then, once I had established these local consequences, I worked to relate these local consequences to *therapeutic functions*. This work of relating conceptually straddles both those SIKs to which participants are demonstrably orienting and the SIKs to which I make more tenuous, less immediately demonstrable links. I will discuss this latter, more tenuous linking, for example, the drawing of clinical implications, in the very next section.

3.2.2.3 Evaluating and drawing implications for therapeutic practice Articulating the therapeutic function of the findings and their relevance for practice necessitates a move beyond a purely CA focus in participants' interests and priorities as displayed in a particular interaction. Such a move requires sufficient knowledge of SIKs to facilitate interpretations of the practical implications of the CA descriptive findings, such as suggesting elaborations, extensions, corrections of existing SIKs etc. The SIKs used in drawing such implications might come from therapeutic principles and concepts, researchers' own clinical judgements and experiences and evidence from the clinical and research literature. These interpretations and implications may also result in evaluations and prescriptions regarding how therapists *ought* to carry out therapeutic interactions. The key conceptual point is such SIK-informed interpretations and implications may use the CA findings as evidence, but these CA findings still remain conceptually independent of the interpretations and implications.

Peräkylä and Vehviläinen (2003) argue for the potential for a fruitful dialogue between CA findings and existing SIKs, to be facilitated by Conversation Analysts making suggestions for elaborating, extending and correcting SIKs etc. Nonetheless, with a concern for maintaining appropriate divisions of labour, they also acknowledge that Conversation Analysts should not attempt tasks like the evaluating SIKs or developing therapeutic norms, which might be more appropriately executed by those with comprehensive knowledge of relevant therapeutic SIKs and, presumably, who also hold a professional stake in how the SIKs develop. Based on my own therapeutic practice and training (cf. section 3.2.5), I advanced some recommendations, suggestions

and re-conceptualizations of SIKs relating to meta-therapeutic dialogue in the current thesis. However, as I have argued, such recommendations are most correctly conceptualized as adjuncts to the actual CA research.

In order to maintain and trial this conceptualization of SIKs, I discussed any practical implications in a separate sub-section after the sections presenting the CA findings proper. This concretely maintained the distinction between CA findings and the drawing of practical implications as stemming from different domains of knowledge. The CA findings are based on participants' demonstrable actions and treatments, whereas implications for practice draw on these CA findings but then go beyond them in relating them to other SIKs and making evaluations etc. Another advantage of presenting the implications directly after each analytic sub-section is that it maintains this conceptual distinction while still also presenting a clear path from the CA findings to their practical implications (cf. section 3.2.3.3).

3.2.3 Practical issues in using CA to bridge the research-practice gap

As discussed in Chapter One, addressing the research-practice gap can be achieving using *practice-based* research to produce *practice-relevant* findings. Previous researchers have considered findings to be *practice-based* if they focus what participants actually do in routine therapy sessions (e.g. Barkham et al., 2010; Henton, 2012). My initial assumption was that such practice-based findings, remaining close to the concrete actions of therapists and clients, can then be considered *practice-relevant* since this close relation with concrete actions should produce informative findings for therapists to reflect upon. However, Peräkylä (2013) further notes that studies which address *clinically relevant* issues would help to ensure that applied CA investigations in therapeutic settings have relevance for, and will engage, therapeutic practitioners. There is an issue here as to whether findings being *practice-relevant* (i.e. describing concrete practice) fully equates to also being *clinically relevant* or whether there is some bridging work to be done between the two. In this thesis, I have endeavoured to ensure that findings were both practice-relevant and also clinically-relevant. Sections 3.2.1 and 3.2.2 have also worked to conceptually clarify how it is possible to

obtain such relevancies from CA findings by carefully relating them to SIKs. In the current section, I will outline some further issues which I see as impacting on the extent to which practice-relevant findings can be considered clinically-relevant.

3.2.3.1 Focus on re-occurring interactional dilemmas As explained in Chapter One, I attempted to focus the analysis on re-occurring interactional dilemmas, which participants demonstrably oriented to, as a means of ensuring that the findings would have some interest for practitioners. My assumption here was that such dilemmas would be clinically relevant to practitioners as touching on recognisable problems they often have to resolve while practicing.

3.2.3.2 Developing feasible implications An obvious means of bridging the practice-research gap would be to use CA findings from the current project to refine and develop recommendations for practice and training around meta-therapeutic therapeutic dialogue. Indeed, other applied CA projects have done so or recommend doing so, including Stokoe's (2014) Conversation Analytic Role-Play Method (CARM), developed to train call-handlers on a meditation helpline for neighbourhood disputes. Kitzinger (2011) also describes how she discussed CA findings of individual practitioners' interactions with the individuals themselves, to personally explore the relevance of the findings for their individual practice. Pino (2016), Strong (2003) and Peräkylä (2011) also suggest that CA materials can be used by practitioners as reflective aids. However, Peräkylä (2011) also argues that while CA findings can help practitioners conceptualize or better understand the import of their interventions, it is probably not feasible to suggest that such findings can be used in the manner of Antaki's (2011) *interventionist applied CA* to effect changes in practitioners' behaviour; for example, to recommend one turn design and to avoid using other designs. Peräkylä argues against this possibility, firstly, on the grounds that CA findings focus on pre-reflective, tacit aspects of practice which might lie beyond practitioners' conscious awareness and control. Secondly, he also cites the variability and responsiveness in therapists' interventions, which appears to be necessary if they are to facilitate beneficial outcomes across different clients and treatment phases. That is,

recommending highly specific interventions would therefore seem to work against findings showing the importance of responsiveness in therapeutic practice (e.g. Stiles, Honos-Webb & Surko, 1998). Peräkylä (2011) further suggests that CA research in psychotherapy might do well to focus on better understanding responsiveness (e.g. in terms of alignment and affiliation) in therapeutic interactions – as opposed to searching for specific therapist behaviours which might be therapeutically effective.

Peräkylä's (2011) point regarding the variability of therapeutic interactions, and of the importance of conceptually allowing for, and investigating, responsiveness, is highly pertinent given the current common factors findings on therapeutic processes and outcomes (cf. Chapter One). Analytic findings and any implications drawn need to be able to accommodate the reality of responsiveness by therapists. Nevertheless, in the current project, I have also invested some focus in comparing and contrasting specific practices, including highlighting when certain practices are clearly not very consistent with existing SIKs. I have made some gentle recommendations as to possible routes forward, but always with the caveat that particular practices may be effective for different purposes in different contexts.

I furthermore focused on these specific practices due a slight questioning of Peräkylä's (2011) other argument that it might not be possible for CA findings to ever change practitioners' pre-reflective actions. Another, contrary possibility is that CA findings regarding specific practices could subsequently be used to develop skills-and-drills exercises, which first draw practitioners' attention to specific practices and them repeatedly drill them in carrying out alternative practices in simulated environments. There are, of course, practical problems associated with the validity of interactions in simulated activities (e.g. Stokoe, 2013). Nevertheless, it remains an open empirical question as to whether such exercises, derived from CA findings, could beneficially contribute to changes in how therapists practice. My project will not seek to directly answer this particular empirical question, but some of its findings could potentially be used to develop focused skills exercises.

3.2.3.3 Presentation of CA findings and clinically-focused discussions I aimed to present implications from these findings in a way which could practically inform training and practice in meta-therapeutic dialogue regarding methods. However, the nearness to practice or practice-relevance of CA findings actually creates another challenge in achieving the current project aims: CA findings can often end up being *practice-near* but *practitioner-far*. That is, although CA findings closely describe what therapists and clients actually do, these findings do not always seem clearly or readily accessible for practitioners (Gale, 2000*;* Peräkylä & Vehviläinen, 2003). Reasons put forward for this include the use of technical CA terms and transcripts.

This gap between being practice-near and practitioner-near is understandable since the drawing of practical implications is a dedicated task in itself, requiring a certain level of competency in both CA and in therapeutic SIKs (Peräkylä & Vehviläinen, 2003). The conceptual issues in clearly maintaining the boundaries between these two domains of knowledge have been discussed in section 3.2.2. For now, I mean to highlight the broad practical challenge and effort involved in creating a dialogue between CA findings and existing SIKS that practitioners can engage with.

This challenge in rendering the practice-near findings of CA practitioner-near can be further accentuated if a large number of analytic observations are presented before practical implications are discussed. Readers unused to reading CA findings may then be overwhelmed and unable to recall the details of the CA analysis when reading the practical implications. This results in an unnecessary obscuring of the chain of reasoning from CA findings to practical implications. Thus, in the ensuing chapters of this thesis, I have implemented a possible solution to this gap between the practice-relevance and clinical relevance of findings. I have positioned *clinically-focused discussions* at the end of each analytic section instead of the usual format, which would be just once at the end of the chapter. This innovation results in several discussions of practical implications in each empirical chapter, which should render the findings more accessible to psychotherapy researchers and practitioners.

3.2.4 Epistemological status of audio recordings

This distinction in CA between the actual data of participants' interactions and recordings of these interactions encompasses the likely possibility that recordings may not capture the interactional phenomenon of interest in full detail as it actually happened.

In the current research project, efforts were made to transparently evidence the analysis in a rigorous manner, such that there were no un-evidenced claims regarding how participants are responding to each other. Nonetheless, the existing audio-recordings from the Cooper et al. (2015) study are a limited representation of the actual interactional data which occurred between therapists and clients since, unlike video-recordings, audio-recordings do not depict most non-verbal interactional features. However, if my analyses of the audio-recordings do indeed rigorously describe how participants are hearably responding to each other, then any (now hypothetical!) inclusion of video-recordings would enrich and complete my findings, that is, rather than invalidate or contradict them. This leads to a conceptualization of findings from the current project as essential scaffolding which would remain in place if the additional descriptions derived from video-recordings could depict more of the detail of the original data.

3.2.5 Reflexive considerations

Here I will offer some reflections as to how my professional and academic background and my political commitments may have contributed to some of the foci of this research.

Like Peräkylä (2011), I am a CA researcher who also practices therapeutically. I trained as a humanistic counsellor and I have been working as a qualified practitioner for several years in community and primary care settings. Thus my background as a professional counsellor gives me some familiarity with the SIKs available to pluralistic therapists through their training and clinical experience (cf. section 3.2.1). This is useful for the current project since it helps me to recognize when participants might be orienting to these SIKs (Peräkylä & Vehviläinen, 2003). A further advantage is my awareness of other SIKs, which might be deemed more tenuously relevant to participants' actions at any particular moment (Leudar et al., 2008). However, a potential

disadvantage is that this familiarity may interfere with my ability to do CA proper without harking back to SIKs which participants themselves are not orienting to. Realizing my project could be subject to this potential blurring of boundaries has probably given impetus to my efforts to conceptually clarify the relations between SIKs and CA findings. My hope is that grappling with grey areas can lead to some innovative outputs – or at least, count as attempts towards such outputs. Added to that, my undergraduate degree was in Anglo-American analytic philosophy. I think some part of me is always drawn towards the familiar activities of drawing distinctions and attempting to clarify and conceptualize the workings of a complex process, such as the current project of applied CA.

There is a further question as to whether I have equally inhabited each of the CA and therapeutic perspectives or whether I have invested more time and effort in one. My subjective experience of carrying out this research was that I felt mired in the CA world and found it extremely challenging to link back to, and articulate, therapeutic relevancies. I have a sense here of chasing relevancies, of trying to catch them, but of remaining empty-handed more often than not. I wonder what underpins this sense. In Chapter Nine (section 9.1.3), I briefly admit and rationalize this experience as a mismatch between the complexity of our interactions and how we have traditionally glossed and described interactions in professional contexts like therapy. But maybe there are other factors at play here too. Maybe I have been struggling to hold on to the two-hatted role of researcher-practitioner. Maybe I am personally more suited to keeping just one hat on. Or maybe, attempting to concretely bridge the research-practice gap is a more demanding activity than anticipated in my research aims.

My political views have also played a role in determining the current research foci. As a white, queer female born into a lower-middle class background in rural Ireland, I am personally committed to following, and developing, feminist and other social justice perspectives. As outlined in Chapters One and Two, there is a clear need for discovery-oriented research regarding the notion of *meta-therapeutic dialogue* in therapy. However, perhaps I was personally drawn towards this particular gap in the research since it holds the tantalizing promise of documenting genuine

mutuality and egalitarianism-in-practice – while still another part of me is motivated to focus a critical eye on whether such an ideal is even achievable in real-life situations, given the multitude of social structures and relations, which shape us and which we usually renew each time we act and which cannot just disappear during therapy sessions (Heritage, 1984; Proctor, 2017; White & Epston, 1990).

And yet, my thesis is not explicitly feminist or critical in its aims. Instead, I adopted an orthodox Conversation Analytic focus – apart from the few excursions which I have conceptually permitted myself, in order to articulate possible clinical relevancies etc. (cf. section 3.2.2). This method selection displays a trust of mine in the analytic discipline of CA, a trust that studying and documenting how therapists and clients concretely interact at the micro-level can make a valuable contribution. A valuable contribution to our knowledge of how we, as therapists, concretely interact with clients, in the name of prescribed ethical ideals, like meta-therapeutic dialogue. The method I selected does not facilitate me to extrapolate from micro-level interactions to macro-level structures, but my findings can represent a worthwhile link in the chain of relations between these levels (Kitzinger, 2000; Silverman, 1997).

3.3 Method

Pluralistic therapy was considered an appropriate source of data for the current study since one of its distinguishing features is to encourage clients and therapists to continually engage in meta-therapeutic dialogue throughout the therapy.

3.3.1 Data

Audio-recorded sessions of pluralistic therapy were sampled from the recent U.K.-based multi-site pilot study investigating the effectiveness of pluralistic therapy (Cooper et al., 2015). This study investigated therapeutic outcomes, retention rates, and user satisfaction for *Pluralistic Therapy for Depression*. The specific therapy conducted in this study, *Pluralistic Therapy for Depression*, was based on a manual designed by the developers of pluralistic therapy (McLeod & Cooper, 2012).

The decision to use existing audio-recordings from the Cooper et al. (2015) study was taken for both ethical and pragmatic reasons. It was considered ethical to fully utilize existing recordings to avoid an unnecessary new data collection phase and the attendant risks associated with this for participants. Furthermore, the use of existing recordings was time-saving for the current project due to the elimination of the need to collect new recordings of interactional data.

3.3.1.1 Permissions/ethical approval Ethical approval to collect the original data for the Cooper et al. (2015) study was granted to the Principal Investigators by the relevant Ethics Committees at each study site. This ethical approval included the condition that informed consent would be obtained from all participants (i.e. both clients and therapists). The information given to participants as part of this consent process clearly stated that they could withdraw their data from the project at any time without consequences. So, for example, in the case of clients, their subsequent decision to withdraw from the study would not affect their counselling if this was still in progress. Participants' informed consent also covered the use of their data in future research projects unless the participant asked for this to be withdrawn. Finally, as part of this informed consent process, there was an opportunity for participants to give further, additional consent for audio-recordings of their sessions to be used for teaching and demonstration purposes.

The current research project was submitted for ethics consideration in the Department of Psychology at the University of Roehampton and was approved under the procedures of the University of Roehampton's Ethics Committee on 08.09.14. As part of this process of gaining ethical approval for the current research, statements of permission were obtained from the Principal Investigators of two of the participating research sites in the Cooper et al. (2015) study (cf. Appendix C). Thus, data from just these two research sites was obtained for use in the current study.

3.3.1.2 Anonymization As per the ethical permission for this project, I anonymized all transcripts and written notes regarding the data using pseudonyms for all proper nouns (i.e. for individuals, places and organizations). Furthermore, in a few cases participants described unusual

circumstances. In these cases, I changed some further concrete details (e.g. career), to render the cases less identifiable.

In data sessions and conference presentations, I only played extracts of recordings for sessions in which both client and therapist had given permission for this. I also refrained from playing audio-recordings at psychotherapy research conferences in case this resulted in therapists being identified. Where audio-recordings were played, all proper nouns were digitally silenced in recordings.

3.3.2 Participant characteristics

Clients were offered pluralistic therapy as part of the Cooper et al. (2015) study if they scored 10 or higher on the Patient Health Questionnaire-9 (PHQ-9) at assessment, indicating at least moderate levels of depression. Potential clients were not offered therapy if their primary presenting problem was assessed as psychosis, personality disorder(s), or drug use.

Both trainee and qualified therapists participated in the Cooper et al. (2015) study. The trainee therapists were in the final two years of counselling psychology doctorate training in the UK. Qualified therapists had an average of 20 years' post-qualification experience. As part of their basic professional training, all therapists had received training in person-centred/humanistic practice, along with varying levels of training in cognitive-behavioural and psychodynamic therapy. All therapists had also received training on the pluralistic approach to therapy and worked in a pluralistic way for the purposes of the study. They received clinical supervision from one of the developers of pluralistic therapy.

3.3.3 Features and structure of Pluralistic Therapy for Depression

The *Pluralistic Therapy for Depression* manual (McLeod & Cooper, 2012) was intended as a first articulation of this treatment, with further refinements to follow the completion of the Cooper et al. (2015) study. The manual was also specifically designed for trainee therapists currently on training programmes which promoted the use of evidence-based therapeutic practice.

In the manual, the authors reiterate the basic principle of pluralistic therapy that it is essential for the pluralistic therapy to identify and highlight the client's "own ideas about what will be helpful for them" and to "mobilize the client's strategies for change". This is to be achieved by the client and therapist engaging in collaborative conversations regarding the client's goals and the therapeutic tasks and methods which can be used to achieve these goals. Cooper and McLeod (2011) also developed a Goals Form which was available for use in the *Pluralistic Therapy for Depression* to help the client and therapist discuss, develop and record clients' therapeutic goals.

McLeod and Cooper (2012) highlight that a competent pluralistic therapist should be able to draw upon sufficient interventions from a range of approaches in order to be open to different possible problem understandings and methods which different clients may find helpful. The *Therapy Personalization Form* (Bowens & Cooper, 2012) was available for clients and therapist to use to discuss their client's preference around how the therapist could work with them. McLeod and Cooper (2012) also suggest that the therapist could able offer the client a "menu" of therapeutic methods or activities, which the client and therapist can then use to construct a plan for the therapy (e.g. Table 1 in Chapter One). They also stress the continual need for meta-therapeutic dialogue, which the therapist should create in the form of collaborative conversations around the therapeutic goals and methods. Finally, in keeping with the strengths-based approach of pluralistic therapy, they also emphasize that clients should be aware of the potential contribution of cultural and social resources which may be available to the client for facilitating therapeutic change; for example, social networks, customs, literature, film, spiritual outlets, exercise routines etc.

In the course of providing *Pluralistic Therapy for Depression*, specific interventions should be selected and adjusted on the basis of collaborative conversations between the client and therapist regarding what might work best for that particular client (McLeod & Cooper, 2012). They also offer a summary of the possible change processes which may be therapeutic helpful to clients experiencing depression. These change process range from cognitive interventions to understanding the significance of the family systems to exploring and changing patterns of relationship to becoming more aware of feelings and the meaning they may have for the client.

The manual also sets out the stages of *Pluralistic Therapy for Depression*, which the authors view as being common to many other forms of therapy and which are as follows: In Stage 1 (e.g. sessions 1-2), the therapist and client develop a collaborative relationship and elicit the client's story. In Stage 2 (e.g. sessions 3-5), they construct a preliminary shared formulation and/or plan of therapeutic work. In Stage 3 (e.g. sessions 4-12), they focus on specific change tasks while also continuing to engage in meta-therapeutic dialogue to explore whether the therapeutic activities are optimally helpful or whether changes could usefully be made, while in Stage 4 (e.g. sessions 13-15), they bring the therapy to an end, review and consolidate progress and address any client concerns and potential future relapse scenarios. The authors highlight that since pluralistic therapy involves being open to multiple therapeutic possibilities, it is likely that, for some clients, the therapy may more helpfully unfold in a manner other to the four stages outlined above and with more or less sessions for each stage. Furthermore, the manual specifies that *Pluralistic Therapy for Depression* is time-limited, with each client being offered a maximum of 24 weekly sessions with the exact number to be decided by the client and therapist according to the individual client's needs (McLeod & Cooper, 2012).

3.3.4 Data sampling

The majority of client-therapist pairs participating in the Cooper et al. (2015) study gave consent for their sessions to be audio-recorded for the purpose of research (n=25). Due to the exploratory aim of the current project regarding the range of ways in which therapists and clients engage in meta-therapeutic dialogue about methods, I prioritized sampling a range of therapists and did not select pairs on the basis of therapeutic outcomes. However, in order to be able to sample similar numbers of sessions across pairs, I excluded pairs which were recorded as not completing the therapy (n=7). I then selected seven pairs for the current study with the aim of ensuring that pairs were drawn roughly equally from the two participating research sites in the UK (n=2; n=5) and were sampled from trainee (n=3) and qualified (n=4) therapists. Where several possible pairs could be selected on the basis of these criteria, I adopted the further practical consideration of selecting those pairs

which had additionally consented for their recordings to be used for training purposes. Due to a proportionally smaller number of qualified therapists in the Cooper et al. (2015) study, the therapist was the same for three of the four experienced therapist pairs. Table 3.1 displays how these sampling decisions resulted in 7 pairs being drawn from 5 therapists, with 3 of the pairs coming from the same qualified therapist's sessions with 3 different clients.

Table 3.1: Spread of therapist-client pairs across therapists

Therapist 1	**Therapist 2**	**Therapist 3**	**Therapist 4**	**Therapist 5**
Pair A	Pair B	Pairs C, D, G	Pair E	Pair F

For the seven therapist-client pairs selected for this study, no pair met for less than eleven sessions. Six sessions were sampled from each of the seven pairs. The earliest five sessions (including the initial assessment session) were selected, along with one session conducted at approximately the point when two thirds of the therapy was completed. My predominant focus on the earlier sessions of therapy was guided by the assumption that meta-therapeutic dialogue is particularly important in the early stages of the therapy, due to the need for client and therapist to negotiate the goals and methods of the therapy (DeFife & Hilsenroth, 2011; Horvarth et al., 2011; Cooper and McLeod, 2011). The later session was sampled as an exploratory indication of whether therapists still created explicit opportunities for clients to share existing knowledge regarding what might be helpful at the start of the final third of the therapy.

3.3.4.1 Selection of illustrative extracts Table 3.2 (page 95) shows the spread of illustrative extracts presented in this thesis across the pairs sampled. The extracts were selected since they constituted clear examples of the features of interest. Table 3.2 also shows how many chapters each extract appears in. Extracts showing questions about what might be helpful (the focus of Chapters Five to

Eight) are also indicated. Fifteen of the total 28 cases of these questions are presented in the body of this thesis.

Table 3.2 Spread of illustrative extracts across client-therapist pairs

***** = extract showing question about what might be helpful

			Used in Chapter...				
		Extract	**Four**	**Five**	**Six**	**Seven**	**Eight**
Therapist 1	**Pair A**	HDTS	-	✓	-	-	-
		HWYL*	-	✓	-	✓	-
		AI *	-	-	-	✓	-
Therapist 2	**Pair B**	HMU	✓	-	-	-	-
		AM *	-	✓	-	-	-
		SC1 *	-	✓	-	-	-
Therapist 3	**Pair C**	I1	-	✓	-	-	-
		WITBR*	-	✓	✓	-	-
		HDWGT*	-	-	-	-	✓
		SWAWGD*	-	-	✓	-	-
		WBRH*	-	-	-	-	✓
	Pair D	NQA	-	✓	-	-	-
		TTH*	-	✓	✓	-	-
		HCYDT*	-	-	✓	✓	✓
		BW*	-	-	✓	✓	✓
	Pair G	NTAJM	✓	-	-	-	-
Therapist 4	**Pair E**	HWT*	-	✓	-	-	-
		YHAP	✓	-	-	-	-
		HSF	✓	-	-	-	-
Therapist 5	**Pair F**	QUEST	✓	-	-	-	-
		ATCBD*	-	-	-	✓	-
		AIP*	✓	-	-	-	-
		AEYTMTE*	-	-	-	✓	-

Chapter 4: Defining and illustrating *talk about what might be therapeutically helpful*

4.1 Chapter overview

This chapter defines and illustrates the thematic code, *talk about what might be helpful*, which was used to identify instances of meta-therapeutic dialogue with respect to methods. This code was necessary in order to initially identify relevant stretches of talk for the current research project. Such stretches of talk were then potential candidates for a subsequent, in-depth investigation using Conversation Analysis (CA). As discussed in more detail in Chapter Three, there is a distinction between initially selecting talk relevant to the current research focus versus a subsequent CA investigation. Chapters Five through Eight describe this eventual CA investigation in comprehensive detail.

The chapter structure is as follows: the rationale for developing and using this code will first be explained in more detail. Then the thematic code itself will be defined and illustrated using data extracts. Finally, there will be a brief discussion of a number of implications for future research arising from the considerations in this chapter.

4.2 Rationale for using *talk about what might be therapeutically helpful* as a thematic code

Meta-therapeutic dialogue is a guiding principle of pluralistic therapy – "If we want to know what is most likely to help clients, we should talk to them about it" (Cooper & McLeod, 2011, p.7-8) (cf. Chapters One and Two). To achieve the current research aims, there was a need to operationalize the notion of *meta-therapeutic dialogue with respect to therapeutic methods* in terms of the concrete interactions of clients and therapists. The code *talk about what might be therapeutically helpful* was developed to do so.

Meta-therapeutic dialogue is defined as "the process of talking to clients about what they want from therapy and how they think they may be most likely to achieve it" (Cooper & McLeod, 2012, p.7). As summarized by Papayianni and Cooper (2017), this process can encompass talk about shared understandings of clients' problems, talk about therapeutic goals and methods and talk

about clients' experience of the therapy sessions and therapeutic change and ongoing feedback and reflections on whether these understandings, goals and methods should be adjusted or changed. As outlined in Chapters One and Two, the current project focuses on meta-therapeutic dialogue with respect to methods. This focus on how the client might be mostly likely to achieve their therapeutic goals was eventually operationalized as the thematic code of *talk about what might be helpful,* where *helpful* describes therapeutic approaches and/or activities which are beneficial in working towards achieving the client's therapeutic goals. This code was used as a preliminary means of identifying instances of meta-therapeutic dialogue. Such instances could then be considered as potential candidates for a subsequent, in-depth Conversation Analysis.

The word *helpful* was used as a gloss for such talk since the notion of being therapeutically helpful is a commonly used descriptor in the pluralistic therapy literature (e.g. Cooper & McLeod, 2011; McLeod & Cooper, 2012; McLeod, 2013). *Helpful* was not intended to exclude cases of talk in which this word was not present. Rather the code, *talk about what might be helpful*, was intended to encompass all talk about how the client and therapist could work towards the client's goals.

Following Cooper and McLeod (2011) and Papayianni and Cooper (2017), helpful approaches and activities were also considered to be inclusive of talk about activities, actions and resources, which the client could implement outside the therapy session; for example, therapy "homework" or developing their social network. This is appropriate given the focus in pluralistic therapy on mobilizing the client's existing personal, idiosyncratic, social and cultural resources (Cooper & McLeod, 2011; McLeod, 2013).

Papayianni and Cooper (2017) clarify that meta-therapeutic dialogue should involve instances of talk in which clients and therapists are *explicitly* discussing what clients want from therapy and how they are most likely to achieve it. Therefore, the thematic code, *talk about what might be helpful*, potentially excludes more implicit manifestations of relevant instances of talk about therapeutic methods. However, given the lack of research regarding meta-therapeutic dialogue, the decision was taken to prioritize exploring explicit instances.

4.3 Application of thematic code

The application of the thematic code, *talk about what might be helpful*, first involved listening to the full sample of 42 sessions and logging and roughly transcribing possible instances.

Possible instances of the code were selected using the following considerations. First, instances of talk were noted which extended topically beyond the content of the client's problematic experiences. This was guided by the idea that meta-therapeutic dialogue with respect to methods should consist of talk about the therapeutic process rather than talk which focuses solely on the details or content of the client's difficulties (Hanley, Sefi & Ersahin, 2016). For illustrative purposes, Section 4.3.1 presents a case of talk which is not meta-therapeutic talk since it *does not* extend beyond the content of the client's problematic experiences.

Second, for talk which did extend beyond the content of the client's problematic experiences to discuss the therapy itself, I distinguished between instances of meta-therapeutic talk and instances of meta-communication (Rennie, 1998) about how the client and therapist's were experiencing the here-and-now therapeutic process (cf. Chapter Two).

Third, for instances of meta-therapeutic talk, I distinguished between talk about therapeutic goals versus about therapeutic methods. Section 4.4.4 illustrates how a therapist practically distinguishes between instances of meta-therapeutic talk about goals versus about methods.

Finally, when collecting instances of meta-therapeutic talk about methods, I included both instances which focused on past or present methods the client had found helpful as well as more future-oriented discussions regarding what *might* be helpful for the client. This more future-oriented discussion is technically closer to the definition of meta-therapeutic dialogue about methods as talk about how the client "may be most likely to achieve" their goals (Cooper & McLeod, 2012, p.7). However, as suggested by Cooper and McLeod (2011), talk about what has been or is helpful can lead to talk about what might be helpful. Furthermore, as Cooper et al. (2016) emphasize, meta-therapeutic dialogue is considered to be an ongoing process throughout the therapy, which means that client feedback about current or past methods which have been used in the therapy forms an

essential part of meta-therapeutic dialogue. Sections 4.4.3 and 4.4.4 present, respectively, questions about the past/present and a more future-oriented question regarding what *might* be helpful.

The current chapter presents an illustration of different instances of the code *talk about what might be helpful*. A survey of instances of this code was not systematically conducted, which would have provided evidence regarding the reliability and validity of resulting frequencies. Nonetheless, the discussion of extracts in this chapter will include my impressions of the relative frequencies of different varieties of *talk about what might be helpful*. However, these impressions should be treated as preliminary and indicative only, pending a more systematic survey.

4.3.1 Role of CA in the current chapter

The CA method was not used when initially applying the thematic code *talk about what might be helpful* to the data. However, I have subsequently used CA to a limited degree for the purposes of presenting illustrative examples of the thematic code in the current chapter. These presentational purposes included using CA to identify sub-varieties of *talk about what might be helpful* in terms of participant actions, like questions and suggestions. CA is also used in the current chapter as a means of illustrating and describing the interactional context of selected instances. This presentational use of CA is intended as an introductory precursor to the upcoming Chapters Five to Eight, which utilize CA more fully.

4.3.2 Illustration of talk which is not meta-therapeutic

Extract HMU contains some talk which is not meta-therapeutic since the sole topical focus is on the details of the client's problem rather than their therapeutic goals and therapeutic methods.

Extract HMU *Session#1/Start19minutes/PairB*

```
1  C:    ((continuing)) then I would have felt, maybe I could have supported
2        her more. [An ]d then maybe the outcome,
3  T:              [Mm.]
4  C:    [wou]ld have been different.
5  T:    [Mm.]
```

T: Mm,
C: Ehm,
T: .Hh .pch you feel as if, because he didn't like her being around,
C: Mm,
T: And made that fairly known to you, .hh
C: Yeah.
T: You then didn't (.) do as much, you think as you might have [done]
C: [Yeah.]
T: for your mother,
(0.3)
C: Mm=
T: =And it's al:most like asking yourself could this all have actually been very different.
C: Yeah.
(0.6)
C: [(There's no-)]
T: [And it's a]s if he's then part of the reason why you think this is where you ended up and, [.hh]h that's kind of ha::rd.
C: [Ye:ah.]
C: Mm.
(.)
T: And you say the things you wouldn't- then feel you could say to him,
C: °Yeah, >accidental kind of argument.°
T: So that, feeling you have, [the, y]ou know, this is where is where
C: [Yeah,]
T: we're a:t, and maybe, the way you were, and that- (meeting me) like this, .hh °↑isn't something you'd sh#are with him particularly.°
C: Yeah, 'cause I just think it'd be easier to: .h not let him know I guess, >because I can't be [deal]ing with the arguing.
T: [Mm.]
T: Mm.
C: °So I'd rather just- k- keep it to myself.°
T: Mm.
C: °So,°
T: °Okay, rather kind [of]° .hh bottle it up.
C: [Yeah.]
C: Mm.
T: Hhh and keep it all inside.
C: Yeah.
(0.6)
T: Which is what you're doing I guess.
C: Yeah and then I guess it's just, uhm, °got too much°.
T: Mm.
(1.0)
T: How do you mean it's got too=much- Help me to understand what you mean by that, [a little bit .hh]
C: [Because I guess] I feel like everything el:se, the:n, uhm, has just been something else to try and cope with, [.hh] whereas
T: [Mm.]
C: I think I probably could have ((continues))

We join the interaction as the client comes to the end of a troubles-telling turn in lines 1-4. The therapist offers several, interlinked gist formulations (i.e. lines 8-14, 17-18, 22-23, 27) and, finally, an upshot formulation in lines 29-32. The client minimally confirms these formulations in lines 19, 24, 30 and produces an extended confirmation in lines 33-37, with ends with the description that they have been keeping their discontent to themselves rather than discussing it with the relevant party. Based on the client's just-prior talk, the therapist, in lines 40 and 43, offers an upshot formulation regarding the client's prior comment of keeping it to themselves: "°Okay, rather kind [of]° .hh bottle it up. / Hhh and keep it all inside." This formulation offers a *recognition* or display of understanding of the client's experience, by speaking from within this experience and by focusing their talk on this experience of the client's, both of which practices treats the experience as real and valid (Voutilainen, Peräkylä & Ruusuvuori, 2010).

This client responds to therapist's recognition of their experience by agreeing and then assessing their current difficulties: "I guess it's just, uhm, °got too much°" (line 47). The client's assessment makes use of the idiomatic phrase "°got too much°" and contributes to bringing the troubles-telling sequence to an apex (Jefferson, 2015). Both the therapist's upshot formulation about the client's current coping strategy and the client's idiomatic assessment create a juncture, wherein the participants could relevantly switch from exploring the content of the client's difficulties to discussing potential therapeutic changes and helpful activities. However, the therapist poses a question in lines 50-51, which focuses the talk on further exploring the details of the client's difficulties: "How do you mean it's got too=much- Help me to understand what you mean by that". This question thus moves the talk away from meta-therapeutic relevancies for the time being and remains with the therapeutic relevancy of exploring the client's experience.

For the purposes of the current project, I assumed that talk which is *not* meta-therapeutic predominantly consists of troubles-telling by the client and experientially-focused talk by the therapist, achieved through formulations, questions and interpretations. Voutilainen, Peräkylä and

Ruusuvuori (2010) made a similar kind of distinction between talk in therapy sessions that focuses on elucidating and exploring the client's private experiences and talk that focuses on other issues like the external situation of these experiences. Their distinction does not cohere with mine, since in the category of *talk which is not meta-therapeutic*, I would include both talk focused on the client's experiences as well as talk about external situations related to these experiences. However, our two distinctions have a similar thrust in endeavouring to tease out and elucidate different forms of therapeutic business. For example, in the case of meta-therapeutic talk about methods, as well as extending topically beyond the content of the client's problematic experiences, we might further suppose that meta-therapeutic talk will involve some problem-solving features necessitated by discussions on regarding what methods or activities or actions the client and therapist can undertake to work towards the therapeutic goals. These problem-solving features talk about what might be therapeutically helpful will be analysed and discussed further in Chapters Five and Six.

4.4 Illustration of variety of instances of talk about what might be therapeutically helpful

4.4.1 Formal opportunity for therapy personalization

Extract QUEST shows a client and therapist engaging in what I am calling a formal opportunity for personalizing the therapy using a tool called the *Therapy Personalization Form (*Bowens & Cooper, 2012). This was counted as an instance of meta-therapeutic talk regarding methods because client responses to this form involve reporting preferences and views on what they think might be therapeutically helpful in the therapy sessions in order to work towards their therapeutic goals (Cooper & Norcross, 2016). Examples of preferences indicated on the *Therapy Personalization Form* are whether the client would like to focus on the past, present or future and how much they would like the therapist to be supportive or challenging.

Extract QUEST *Session#1/Start9minute/PairF*

```
1  T:    .hh So- uhm, just kinda how- things went last wee:k, and .h having
2        these three goals so far, uhm, how would you sa::y, uhm, is, (.) like
```

```
3         I have another questionnaire to ask you about=more .hh what, hhow you
4         would like me to work? [and,] maybe that would helpful .hh for nyou=
5   C:                           [Mhm.]
6   T:    =and=me to know what I need to do >to make sure that we .hh you're
7         getting the most that you want? o:ut of this time, and that- we
8         arrive at these g#oals so that y#ou're, you're feeling like
9         you're=you're working towards what you w#ant to be working [towards]
10  C:                                                               [Mhm.   ]
11  T:    here. .hh uhm, so why don't we do this other questionnaire ↓quickly
12        and that will give me an idea of what you expect #out of
13        m[e:.  ]
14  C:     [Sure,] yeah.
15  T:    .pch okay. .hh so:, uhm:, basically, .hh this is questions about how
16        you want me to work an:d, eh the first question is, would you want
17        me: to, use a lot of techniques and exercises .hh or to not use any
18        techniques or exercises, >and then,< zero in the middle is no
19        preference. Or if you want a ↑lot of techniques?
20        Or not a lot, [.hh]
21  C:                  [Ok ]a:y, (.) ehm:, I would say >maybe like, (0.6) two
22        towards the:, having technique[s? °The same]
23  T:                                  [Okay,       ]
24  C:    as you put there.°
25        (0.3)
26  T:    °Okay,° .shih would you want me: to take a lead in therapy? or:, uhm,
27  °#uh° would you want to t#ake a l#ead in th#erapy.
28  C:    Uhm, probably a four towards (.) you taking a lead, [°I guess°] yeah.
29  T:                                                       [Okay,    ]
30  T:    Would you want me: to show my personality ((continues))
```

The client and therapist have just finished completing the Goals Form just before Extract Quest begins. We join the therapist as they introduce the *Therapy Personalisation Form* (i.e. the "questionnaire" mentioned in line 3) and provide an extended account for now filling it out (lines 1-13). This account includes a gloss of the purpose of the questionnaire as "to make sure that we .hh you're getting the most that you want? o:ut of this time, and that- we arrive at these g#oals" (lines 6-8). This gloss sets up the ensuing talk as focusing on factors which can help the client reach their therapeutic goals. As such, this gloss also provides evidence for categorizing this talk as an instance of the thematic code of *talk about what might be helpful*.

After the client agrees to now filling out the questionnaire (line 14), the therapist moves to read out the first question from the *Therapy Personalisation Form* (lines 16-18). They initially design this reading-out as an alternative question using "or" (Hayano, 2013), before subsequently describing the continuum along which the client should fit their response (lines 18-20: ">and then,<

zero in the middle is no preference. Or if you want a ↑lot of techniques? Or not a lot,"). The client responds (lines 21-24) by indicating their position on this continuum ">maybe like, (0.6) two towards the,". Thus the client answers, but the content of their answer does not extend beyond the scope outlined in the question. In lines 26-27, the therapist asks a second question from the *Therapy Personalisation Form* and the client similarly responds in line 28 by indicating their position on the continuum but otherwise not extending beyond the scope of the question.

The *Therapy Personalisation Form* was discussed once by each therapist-client pair in the current sample, which makes it a relatively infrequent variety of talk about what might be helpful. There are different ways in which clients and therapists can approach the tasks of filling in and discussing this form. In Extract Quest, the therapist and client fill out the *Therapy Personalisation Form* using a *tick-box* approach as opposed to one which facilitates narrative responses from the client (Toerien et al., 2011b).

4.4.2 Suggestions by therapists

Extract YHAP illustrates the therapist making a suggestion to the client regarding what might be therapeutically helpful, thereby counted as another instance of meta-therapeutic dialogue with respect to methods. We join the participants as the therapist is presenting a rationale (lines 1-7; Cooper & McLeod, 2011) for giving information about a therapeutic activity to help the client become more aware of their moods.

Extract YHAP *Session#9/Start31minutes/Pair E*

```
1  T:   And I just brought this out because when you said (0.5) ehm:
2       ↓what you're doing seems to >have an impact on your mood and
3       you're #out of a routine at the minute .hh ehm, (0.6) .pch
4       activity diaries can help .hh well (0.4) .hhh (0.5) °b-° they
5       can basically help us to see wha:t h you're you are doing
6       throughout your week, how you're spending your time and how
7       that's impacting your mood?
8  C:   °Mm.°
```

T: Ehm so what I'd ask you to do is .hh so let's say you'd fill ou:t .hh .pch Tuesday what time you got up at th- the things that you've done .hh and even if it is just like .hh ↓watched TV or ↓was in bed you know it doesn't actually have to be: .hh y'know I went out and went to the cinema,
C: Yeah.
T: So just anything that you're doing .hh and if you rate ↓your: E- Keh. mood? in it?
(0.7) ((sound of writing))
T: Ehm so if you just put a score down from zero to ten (0.3) depending on how: low (0.3) or how happy you've ↑b[een?]
C: [Oka]y.
T: .hh Ehm and you can: (0.8) do you have ↑any preference for how you'd .hh (0.3) rate your mood? You can do it from zero to ha- to t[en]
C: [Zero] to ten's [good.]
T: [or ze]ro to a hundred .hh ehm so it depends on:, (0.5) so zero could be: h sad, (0.7) ((writing)) ten can be: (0.3) happy:, .hh sometimes people do it .hh zero is relaxed .hh ten is stressed.
(2.3)
C: Ehm:
T: So it's whichever °one° makes sense to you however you want to write it.
(0.9)
C: I suppose the sad to happy maybe: yeah.
T: Mhm yeah okay so we write it that way ehm: another thing you can do is ((continues))

In lines 1-7, the therapist gives an account for having taken out an activity diary to show the client. This account shows the therapist's endorsement of the suggested activity since it involves the therapist outlining why their suggestion is reasonable and relevant (Pilnick, 2004). After the client minimally acknowledges this account in line 8, the therapist re-takes the floor to give further information regarding this suggested therapeutic activity (lines 9-13, 15-16, 18-19). This information-giving elaborates the initial suggestion of keening an activity diary. The client minimally responds to this information in line 14 ("yeah") and line 20 ("okay"). It is also probable that the client has non-verbally acknowledged this information in line 17 after the therapist finished their turn in line 16 with rising intonation (Stivers & Rossano, 2010). In lines 21-23, the therapist asks the client as to whether they have any preference regarding what labels they would use to "rate" their mood. The

therapist immediately follows up this question with a suggestion about how this might be done ("You can do it from zero to ten") and the client overlaps to positively assess and accept this candidate suggestion (line 24: "zero to ten's good"). The therapist then moves on to consider further details of implementation for the suggestion (lines 26-28 and 31-32), which makes relevant a further selection from the client in line 34. There is no opportunity for the client to explicitly consider whether the suggested activity would be helpful for them before the therapist moves on to launching another suggestion about a different activity in lines 35-36.

In Extract YHAP, the therapist makes a suggestion to the client, namely, to keep an activity diary. The therapist invests substantial interactional work in giving information to the client regarding the suggested activity. However, this information-giving cannot be considered neutral, since it works to further develop the therapist's endorsement of the activity diary. The information-giving also involves a concomitant lack of opportunity for the client to discuss their views regarding the overall suitability of the activity diary for helping to achieve their therapeutic goals. The lack of opportunity for the client to do this also results in implicit – and therefore potentially ambiguous – commitment by the client to the activity (Heritage & Sefi, 1992).

My strong preliminary impression was that suggestions made by therapist were by far the most common means of initiating talk about what might be helpful. An infrequent subset of these suggestions occurred alongside the therapist eliciting the client's views on the potential helpfulness of the suggestion. An example of this subset will be treated in more detail in Chapter Five. Such suggestions which are followed by elicitations of the client's views could be considered more collaborative and dialogical than suggestions occurring with no view elicitor as to the overall suitability of the suggested activity, as in Extract YHAP above.

4.4.3 Questions about what has been/is helpful

Illustrating another instance of the code *talk about what might be helpful*, Extract HSF contains an instance of a therapist asking a client whether anything has been helpful so far, that is, in the past or

present to date. We join participants as the client as coming towards the end of describing a problem they have been experiencing.

Extract HSF *Session#9/Start20minutes/PairE*

```
 1
 2  C:   .shih Like sometimes if- (0.8) I'm in a particularly bad mood,
 3       >like I'll be< .hh like people just having a joke or a laugh,
 4       like I'll just be- hypersensitive about it? [And] I won't- let
 5  T:                                                [Mhm.]
 6  C:   it show but it just ruins my evening, [or ru]ins my day,
 7  T:                                         [Mhm  ]
 8  C:   .shhhih
 9       (0.5)
10  C:   And I'd like to stop being that, (.) sensitive=I think that
11       was the, yeah one of our- goal things, [.hh ] stop being
12  T:                                          [Mhm.]
13  C:   Hypersensitive about people and situations.
14  T:   Mhm, yeah I think it was, ((rustling sound, taking out Goals
15       Form)) Yeah, "not being hypersensitive about people and
16       situations"=.h so is it that you feel that when you're, (.)
17       when you're in a low mood or when you f:eel s: kinda one of
18       those sensitive issues [have ] been have been touched on,
19  C:                          [Mhm.]
20  T:   .H is that you: become ↓hypersensitive, [.hhh  ]
21  C:                                           [hYeah.]
22  T:   °Mhm.°
23  C:   Ehm, (0.5)
24  T:   .h And is there anything that you've done that's (0.9) helped
25       so far? with, (0.8) with °not being hypersensitive.°
26       (0.7)
27  C:   .shihh (0.5) .pch I suppose being, (0.6) happier, (.) more
28       happy in general? [helps] a bit because you've got a bit more
29  T:                     [Mhm ]
30  C:   of, (0.3) not of guard but like ehm, .h it doesn't matter so
31       much, [But  ] when you're feeling crap anyway it just feels
32  T:         [°Mhm°]
33  C:   like .hh °sort of° (0.3) people chipping away? .h [And  ] it-
34  T:                                                    [°Mhm°]
35  C:   it'd be fine- one minute and then something will just ↓tip me
36       over the edge.
37  T:   Mhm.
38  C:   I can't think of anything that really really helps #it.
39  T:   Mhm. .h So it's usually when your (.) kind of, mood is a bit
40       better or higher, when you're feeling a bit happier ((continues
41       turn))
```

In line 5, the client comes to the upshot of their problem description: “but it just ruins my evening [or ru]ins my day”. In lines 9-12, the client makes an explicit link between the problem they have been describing and a therapeutic goal they have previously discussed with the therapist: “And I’d like to stop being that, (.) sensitive=I think that was the, yeah one of our- goal things”, thus initiating meta-therapeutic talk about *goals* (Cooper et al., 2016).

In lines 26-30, the therapist agrees with the client’s identification of the goal and locates and reads this from the *Goals Form* (Cooper & McLeod, 2011), before producing a candidate formulation regarding the dynamics of when the client becomes hypersensitive. After the client confirms this formulation, the therapist goes on to pose a question as to whether there’s “anything that you’ve done that’s (0.9) helped so far?” (lines 36-37). This question enquires as to what has been helpful or is currently helpful with the client’s problem and thus counts as the initiation of meta-therapeutic talk about *methods* by the therapist.

Extract HSF illustrates how therapists posing questions about what has been helpful in the past or present can achieve a smooth topical transition from meta-therapeutic talk about goals to topicalizing therapeutic methods. Conceivably, this topicalization then prepares the ground for eventual more future-oriented talk regarding what *might* be helpful.

We have also seen how this particular client makes a clear move to initiate meta-therapeutic talk about goals and the therapist follows up with meta-therapeutic talk about methods. This case thus shows the limitations of binary categories which assume the initiation of one meta-therapeutic dialogue by one party only. As shown above in Extract HSF, there are some cases in which both the client and therapist have contributed to the relevance of the therapist’s question about what might be helpful.

4.4.4 Questions about what might be helpful

Extract AIP *Session#4/Start1minute/PairF*

```
 1  T:    ↑Good=yeah >it ↑looks like< >your scores are getting< (.) a
 2        ↑lot  (.) lower #on the sc[ale=so tha]t's good=are you
 3  C:                              [Yea:h     ]
 4  T:    feeling- (.) that- (.)
 5  C:    Yea:h [definite]ly=I fee:l I feel a lot mor:e sort of in
 6  T:          [Okay.   ]
 7  C:    control,
 8  T:    Rig[ht]
 9  C:       [of] everything: [eve  ]n,
10  T:                        [↑Okay]
11        (0.3)
12  C:    Even when thing:s >kind of< have gone a bit wrong:? [or:] have
13  T:                                                      [Mm.]
14  C:    kinda come up, .hh
15  T:    °Yeah.°
16  C:    >I seem to have been able to< (.) deal with it a lot
17        bett[er?=an]d I don't get as kind of, (0.4) into like a state
18  T:        [Right.]
19  C:    a[n:d, .hh]
20  T:     [Right   ] right.
21        (0.7) ((rustling of paper during this pause))
22  T:    °↑Okay° that's really good.
23        (0.5) ((rustling of paper during this pause))
24  T:    °↑Okay°
25        (0.4) ((rustling of paper during this pause))
26  T:    So then as far as <goals go,> .hh so you're finding:, °umph°
27        (0.6) °eh-° kind of like a m- a middle:: (.) ground for all of
28        them?=is .hh there anything in particular that you would find
29        that you would want us to do more to make sure you're
30        reaching: your goals a bit mo:re? O[r,]
31  C:                                      [Eh]m:,
32        (0.5)
33  C:    .hh I th↑ink >just kinda< keep keep going the way we are: I
34        mean I've fe:lt, .hh I've noticed, ((continues))
```

In Extract AIP, lines 1-4, the therapist positively assesses the client's lower scores on the outcome measures and then asks if the client has been feeling this decrease in symptoms. The client responds by confirming and subsequently elaborating on this confirmation (lines 5-19). In lines 26-30, the

therapist produces a so-prefaced question. This so-preface introduces the question as an impending item of business (Bolden, 2009). In explicitly eliciting client views on the therapy so far (lines 28-29: "anything ...that you would want us to do more"), this functions as a feedback question, but it also works as a future-oriented question regarding what might be helpful for the client going forward.

In posing this question, the therapist treats therapeutic methods (i.e. line 29: what the client and therapist "do"), as the means for achieving the client's goals. This treatment illustrates the distinction between meta-therapeutic talk about goals and meta-therapeutic talk about methods. The former focuses on what the client wants to achieve in therapy and the latter on *what* the client and therapist can do to work towards achieve this.

4.4.5 Client initiation of *talk about what might be helpful*

Extract NTAJM depicts a case of the client unilaterally initiating talk about what might be helpful. My preliminary impressions were that such cases were extremely rare in the current data corpus not occurring more than a few times in total across the 42 sessions listened to.

Extract NTAJM *Session#4/Start36minute/PairG*

```
 1
 2  T:   You're describing a state, a kind of, quite a positive state,
 3  C:   Mhm.
 4  T:   .h kinda, seeing some good things in the future:,
 5  C:   Mhm.
 6  T:   A kind of stillness.
 7  C:   Mhm.
 8  T:   ↓Calmness.
 9  C:   Mhm.
10  T:   And a rationality:,
11  C:   Mhm.
12       (3.5)
13  T:   That's good. >Ek [heh< [That's rea(hh)lly good.]
14  C:                    [>Eh  [↑hih >>↑hiiih >>↑hi    ]iih
15  T:   That's really good isn't it,
16  C:   Mm.
17       (0.4) .pch (1.4) Yeah, yeah, it's great. Ehm, (20.7)
18  C:   So what are we going to talk about in the future?
19       (0.7)
20  C:   If I feel good now.
```

```
21        (1.0)
22  T:    .Hh Hh ↓What do you mean?
23        (0.9)
24  C:    I don't know.
25        (14.3)
26  C:    I, Is it okay not to talk about just misery all the time?
27        (0.3)
28  T:    Yea:h, [>okay okay< complete]ly.
29  C:           [Oh, okay >eh he  heh]
30        (0.8)
31  C:    .hh .hh °uh-° Yeah, it would be interesting to explore like,
32        >like like< positive? (1.5) eh::, (.)°things?°
33        (8.8)
34  T:    °What sort of positive things?°
35        (6.7)
36  C:    M::m,
37        (7.7)
38  C:    Oh: (.) I feel here? (.) like °eh-° (1.2) yeah uh::m, (7.5) I
39        feel weird about talking about my- my positive side?
40  T:    Mm.
41        (.)
42  C:    So that's quite unusual, [but] I- I want to try: it.
43  T:                             [Mm.]
44  T:    Mm.
45        (1.6)
46  C:    Because that could be new?
47  T:    Yeah.
48  C:    .h because I kinda get- have the routine, (0.7)/((movement in
49        chair)) talking about like, that stuff.
50  T:    Yeah.
51        (0.4)
52  C:    Uh::, (3.3) and if >I would be able to do that, maybe I-< uh-
53        that would help me to- eh, (0.6) uh:, (1.7) to keep this (0.3)
54        positive state going?
55        (1.0)
56  C:    If I understand it more?
57        (1.4)
58  T:    And also maybe understand what makes it difficult to kind of
59        sta:y (0.3) [within it.] ((continues))
60  C:                [Yeah.     ]
```

In lines 1-9, the therapist produces a gist formulation of what the client has been saying, leaving space for the client to minimally respond to this at several points (lines 2, 4, 6, 8, 10). The therapist then produces an assessment of the client's talk as being "rea(hh)lly good", thus, characterizing the client's prior reports as a positive therapeutic development (lines 12, 14). In lines 15-16, the client

produces delayed but eventually full agreement with this assessment. The client then produces a floor-holding "Ehm," and allows a gap of 20.7 seconds before fully initiating a new sequence by asking what they and the therapist will discuss "in the future" (line 17). In line 19, they add the increment "If I feel good now", which delineates the scope of the question as pertaining to the future activities of the sessions given the positive therapeutic development just discussed. In focusing the talk on possible activities in the therapy session, the client here can be seen to have initiated an instance of *talk about what might be helpful*.

The therapist subsequently asks exploratory questions in lines 21 and 33, which make it relevant for the client to further expand their views regarding the therapeutic direction and methods. The client asks a permission-seeking question in line 25, "Is it okay not to talk about just misery all the time?", which explicitly asks the therapist to confirm what is acceptable or appropriate in the therapy sessions. In line 27, the therapist affiliatively endorses the affirmative of the permission-seeking question. The client goes on to give an extended account (lines 45-55), establishing the therapeutic relevancy of exploring "positive" things (Leudar et al., 2008). In lines 57-58, the therapist can again be seen to endorse the client's account, and by extension, the client's suggestion, by collaboratively continuing the development of a rationale for the client's suggested therapeutic approach.

In Extract NTAJM, the client unilaterally suggests an alternative therapeutic approach. The therapist responds by giving plenty of space to the client to develop their suggestion, while also co-constructing it by endorsing it and eventually contributing materially to its development. This case follows Kushida, Hiramoto and Yamakawa (2017) in illustrating how a client can unilaterally initiate talk about therapeutic approaches. It further illustrates how the therapist might supportively and collaboratively respond to such initiations.

4.5 Summary and implications for future research

This chapter has provided a rationale for investigating instances of the thematic code, *talk about what might be therapeutically helpful* and has illustrated an indicative variety of such instances.

In Section 4.3.1, we discussed an argument for characterizing non-meta-therapeutic talk as *not* extending topically beyond the client's experiences and related difficulties. We also discussed the possibility of meta-therapeutic talk about methods necessarily showing some problem-solving features. This is a potentially valuable conceptual and practical distinction which will be further developed and evidenced in Chapters Five and Six. However, talk which is not meta-therapeutic has been given, at best, a preliminary treatment in the current chapter. Future research could helpfully interrogate the current characterization of such talk and show up nuances and complexities which the current discussion has not highlighted. Furthermore, as discussed in Section 4.3.1, there is a possibility that some instances of non-meta-therapeutic talk may also function as *pre*-meta-therapeutic talk. This possibility has relevance for ongoing research interests in how clients and therapists actually go about meta-therapeutic talk.

In Section 4.4.1, we examined how a therapist-client pair filled out the *Therapy Personalisation Form,* as one instance of *talk about what might be helpful.* There was evidence that this pair used a *tick-box* approach as opposed to one which facilitates narrative responses from the client (Toerien et al., 2011b). In their study, Toerien et al. (2011b) contrasted how a *tick-box* approach tended to involve employment advisors giving more information, whereas in what the authors called more *personalized* approaches, advisors created opportunities for discussion in ways that invited narrative responses from clients, thus facilitating the client to provide more detailed information regarding their individual circumstances. Such a more personalized approach is certainly possible with the Therapy Personalization form as well and researching such instances would be valuable in order to find out how therapists and clients can optimally use these more formal opportunities for therapy personalization and meta-therapeutic dialogue.

Section 4.4.3 showed how therapists' questions to clients regarding what has been helpful to date, that is, in the past or present, achieved a smooth topical transition from meta-therapeutic talk about goals to meta-therapeutic talk about methods. Conceivably such talk might prepare the ground for eventual, more future-oriented talk about what might be helpful (Cooper et al., 2016). This possibility of talk about what *has been* helpful preparing the ground for talk about what *might* be helpful is worth exploring as a potential means of facilitating feasible and sustainable transitions to talk about therapeutic methods.

Section 4.4.3 discussed a case in which the initiation of meta-therapeutic talk about methods could be deemed a co-construction rather than a straightforward, clear-cut initiation by either participant. However, my preliminary impressions indicate that the vast majority of such instances of talk appeared to be therapist-initiated and therapist-led and unambiguous cases of client initiation, such as in Section 4.4.5, were extremely rare. Furthermore, therapists' suggestion of one possible therapeutic activity, which intrinsically endorse the described method or activity, as in Section 4.4.2, seemed by far to be the most common means of initiation, with other means which facilitated more substantial client participation, such as therapists' questions to clients about what might be helpful, being comparatively rare. Land, Parry and Seymour's (2017) systematic review of observational findings regarding shared decision-making practices also found that healthcare practitioners' putting forward of a single, suggested course of action was the most common means of working towards a decision. These preliminary impressions of frequency give further impetus to the current research focus on how therapists might work to facilitate opportunities for clients to collaboratively and dialogically participate in meta-therapeutic discussions about what might be therapeutically helpful. To this end, Chapter Five will discuss some of the different ways in which suggestions can be produced and will consider how these can be considered more or less dialogical ways. Chapters Six through Eight will subsequently focus on how therapists' questions about what might be helpful can promote clients' active participation in meta-therapeutic dialogue about methods to greater and lesser extents.

The ideal progressions from the current illustrative chapter all involve conducting more comprehensive and systematic observational studies of recordings of therapy sessions. This would further develop objective, publicly available evidence regarding the different ways in which clients and therapists actually carry out meta-therapeutic dialogue. On this basis of this more systematic observational research, it would then be possible to develop a taxonomic, quantitative survey of different instances of meta-therapeutic talk. This would help to establish the relative frequency of such talk across therapist-client pairs and create an opportunity to investigate whether there is a relationship between the frequency of such talk and therapeutic outcomes.

Chapter 5: Defining and selecting therapeutic method questions

5.1 Chapter overview

Chapter Four provided a preliminary indication that therapists in the current sample occasionally used *questions* to invite clients to give ideas about what might be therapeutically helpful. In the current chapter, I will argue that investigating these questions in-depth, using CA, will contribute towards fulfilling the research aims outlined in Chapter One. Namely, an investigation of these questions will detail how pluralistic therapists and clients engage in this form of meta-therapeutic talk regarding therapeutic methods. This investigation can also develop implications to inform the practice of meta-therapeutic dialogue and other collaborative and dialogical approaches. Finally, this investigation can provide practice-based examples to inform and extend the ideal prescriptions of dialogical practice in the psychotherapeutic and pluralistic literature.

The current chapter provides an introductory foundation for an in-depth investigation of therapists' questions about what might be helpful, which will be presented in Chapters Six through Eight. This introductory foundation is provided by illustrating and justifying the selection criteria used to build a collection of these questions and by outlining their frequency. Alongside serving as an introductory foundation, the considerations detailed in the current chapter have some clinical implications. This is since the very process of defining and refining the selection criteria raises some distinctions regarding the practice of pluralistic therapy, which have not yet been described in the literature.

This chapter is structured as follows: First, I will introduce the kinds of questions therapists use to invite clients to talk about what might be helpful (Section 5.2). I will then re-cap the method used for the selection process (Section 5.3) before presenting an overarching rationale for conducting an in-depth, CA investigation of these questions (Section 5.4). Subsequently, I will describe and justify the selection criteria used when considering cases for inclusion in the current CA study (Section 5.5). I will then report on the frequency of occurrence of the selected cases (Section 5.6) before finally detailing some clinical implications (Section 5.7).

5.2 Introductory illustration of therapists' questions to clients about what might be helpful

In this section, I will present two initial illustrative examples of questions about what might be therapeutically helpful described. With these questions, the therapist explicitly invited the client to give their own ideas on what might be therapeutically helpful. Following on from the distinction made in Chapter Two between implicit and explicit forms of co-construction, the explicit focus of these questions on *what might be helpful* was considered essential for inclusion in the current collection.

In Extract SC1, the therapist prefaces this explicit invitation with a summary of the prior talk as "kinds of questions we might think about" (lines 1-2). In lines 4-8, the therapist then proceeds to pose a series of grammatically-formed questions to the client regarding what "↑might help you to move on from this point?"

Extract SC1 Session#3/Start37minutes/PairB

```
1   T:   >So those are< (0.3) kinds of questions °th~at° we °might
2        think abou:t?°
3   C:    Yeah.
4   T:   .h Or you might think about. .Hhh ehm: >you know< what is it
5        do you thinkH that ↑might help you to move on H from this
6        point? >Do you have any thoughts< about that=°does° has
7        anything occurred  to you:?=#a:s=has the family thought about
8        memor:ial se#rvice=h#ave you,=
9   C:   =Well we did. we ACTually thou:ght ehm: (0.5) °it was ↑quite-
10       >sort of relatively-< soon °after ((continues))
```

In subsequent chapters, I will examine in more detail the context (cf. Chapter Six) and design (cf. Chapter Seven) of questions such as those in Extract SC1. For the current introductory purposes, it is sufficient to note how the therapist here is creating an explicit relevance for the client to give ideas regarding what might be therapeutically helpful, specifically in this case, regarding what might help the client to "move on". In this case, the topical agenda of the question concerns what might help

the client to "move on" and the action agenda of the question is for the client to answer by providing ideas or suggestions regarding this topic (Clayman & Heritage, 2002). An important feature which contributes to rendering this utterance identifiable as a question is *recipient-tilted epistemic asymmetry* (Stivers & Rossano, 2010). Here the therapist is presenting themselves as unknowing as to the client's own, idiosyncratic ideas or views about what might help them "move on". In responding with an answer in lines 9-10, the client aligns with the question's topical and action agendas by answering and thereby reducing the asymmetry regarding the client's own views.

Similarly, in Extract TTH, in lines 31-33, the therapist asks the client regarding what they would "like to °do°" in the therapy. Again, the therapist is presenting themselves as unknowing regarding the therapeutic activities that *this particular client* would like to engage in. The topical agenda of the question concerns the therapeutic activities the client would like to engage in and the action agenda of the question is for the client to answer by producing ideas regarding this topic. As depicted in lines 34-37, the client initially does not verbally respond to this question. However, subsequently in lines 42-43, the client shows they are treating the question as one about what they can do in the sessions that might be helpful, since they refer to how they would like the therapy to provide "a little help-ing hand". Furthermore, in lines 49-57, in describing their "thoughts" or suggestions regarding what the client could do, the therapist also treats their original question in lines 31-33 as having been about therapeutic approaches and methods which might be helpful for this client.

Extract TTH *Session#0/Start31minutes/PairD*

```
27  T:   °And ability to be able to ↑do:.°
28       (0.3)
29  C:   M:hm
30       (0.3)
31  T:   .HH So WHAT- >I mean IN TERMS of the THERapy here< what's
32       what's your: sense of it, wh=wh=wh: what's your thinking about
33       what you'd like to °do°.
34  C:     .HHH H
35       (1.0)
```

```
*?:  °.shih°
     (1.9)
T:   Or I could tell you my thoughts.
C:   ↑Yeah, I'd be interested in you[r  tho]ughts, I mean-
T:                                    [°'kay°]
     (0.4)
C:   ↓Very generally just- (.) °what I'd said before°, just- .hh
     (0.3) a little help-ing hand would be: (0.4) rea:ll[y ]
T:                                                      [°O]kay°
C:   Appreciated. And if .hh if it could help ↑others as ↑wel:l,
     great. throu:gh recording what we speak a[bout, that'd b]e:
T:                                             [(           )]
C:   wonderful. [.hh    ]
T:               [°Okay.°] .HH Well I GUESS e#h: .h you know,
     listening to where you're coming from. my sense is that you:-
     you know, you got a lot of insight and you've been thinking
     about things. °and you're quite° psycholog:ically ↑minded. .HH
     and it SOUNDS like you're at a point wher:e, it would be
     useful to kinda stand back an:d, °just° reflect on thing:s
     and, .h look at where you wanna go: and how are you gonna do
     that. .shih and I think counselling can be: a useful time:-
     .hh to: kinda talk throu:gh ((continues))
```

5.3 Re-cap of method for selection process

The cases of questions in the final collection all involve the therapist inviting the client to give ideas regarding what might be therapeutically helpful. All cases are derived from the preliminary log of *talk about what might be therapeutically helpful* described in Chapter Four.

In preparation for the selection process, all potential cases of therapists' questions, which *prima facie* invited clients to contribute ideas about what might be therapeutically helpful, were transcribed using CA transcription conventions (Jefferson, 2004). I also transcribed the interactional context prior to, and following, each potential case. These transcripts enabled informed considerations of potential cases using the selection criteria detailed in this chapter.

The process of developing and refining these selection criteria was supported by CA-based evidence showing how participants themselves (i.e. clients and therapists) treated the questions in the potentially relevant cases I had identified. However, the primary impetus in refining the

selection criteria stemmed from the specific research aim of investigating opportunities for meta-therapeutic dialogue as outlined in Chapter One. As discussed at length in Chapter Three, since the selection process is informed by these aims which may be exogenous to participants' interests in the interaction, I conceptualize it as occurring prior to the CA investigation proper in Chapters Six through Eight. In Chapters Six through Eight, the analytic focus will center solely on explicating what the participants themselves treat as important in the interaction.

5.4 Rationale for in-depth CA investigation of these questions

I will now outline a rationale for using CA to investigate questions like the two presented in the previous section. The basic premise for this rationale is that such an investigation contributes towards fulfilling the practice-based research aim (cf. Chapter One) of examining if and how pluralistic therapists and clients concretely participate in meta-therapeutic talk about therapeutic methods. The questions of interest involve therapists inviting clients to contribute ideas about what might be helpful. As such, they constitute one route from exploring the client's difficulties and goals to a consideration of the therapeutic methods which can help the client work towards these goals. Such a movement from exploration of problems and goals towards an explicit discussion of what might be therapeutically helpful is a distinctive feature of pluralistic therapy and of meta-therapeutic dialogue (Cooper & McLeod, 2011; Hanley, Sefi & Ersahin, 2016). An in-depth investigation of these questions therefore cuts to the meta-therapeutic core of pluralistic therapy.

An in-depth CA investigation of these opportunities would also help to fulfil the need, identified by Cooper and McLeod (2011), for research into the concrete ways in which therapists elicit ideas and feedback from clients. Additionally, in Chapter Two, we noted the need for a focus on how clients and therapists *explicitly* co-construct therapeutic methods together. Furthermore, as an invitation to clients to talk about what might be therapeutically helpful, these questions also contribute to creating "a culture of feedback" wherein the client feels progressively more comfortable in sharing what feels helpful or unhelpful (Cooper & McLeod, 2011, p.49). Thus, these

questions potentially contribute generally to our practical knowledge of therapists can build collaborative and dialogical relationships with clients.

As discussed in Chapter Two, the notion of *dialogue* encompasses the ideal of mutually respectful talk, in which each person's perspective is sought out and valued and consensus is the desired outcome as opposed to coerced or imposed agreement. Questions about what might be helpful would appear to be a particularly dialogical opportunity, since they create space for foregrounding the client's ideas. Land, Parry and Seymour (2017) also characterize healthcare practitioners' questions regarding clients' views on treatment options as contributing to a "bilateral approach". The creation of such an explicit invitation for the client to share their views is an important dialogical act when the client may be reluctant or unsure about whether they should contribute (Cooper & McLeod, 2011). However, in accordance with the conclusions in Chapter Two, an in-depth CA investigation is also necessary to ascertain how apparent dialogical opportunities work in practice.

Chapter Four's exploration of the thematic code *talk about what might be helpful* provided another rationale for focusing on these questions. This provided a preliminary indication that such talk was overwhelmingly initiated by therapists. Furthermore, therapist's suggestions appeared to be the most common means of initiation. However, therapists' putting forward of suggestions does not guarantee that clients will then substantially participate in meta-therapeutic talk. These preliminary impressions form another impetus for investigating questions about what might be helpful as one concrete means by which therapists might facilitate clients to participate in meta-therapeutic dialogue. Furthermore, as discussed in Chapter Three, CA is a highly suitable method for investigating how clients and therapists themselves concretely treat these questions and any interactional dilemmas arising. Indeed, a CA investigation may provide some answers as to why these questions are relatively infrequent in the first place. Findings from this in-depth investigation could then be used to develop implications for practice and training.

As detailed in Chapter Two, Ekberg and LeCouteur (2014a) investigated how therapists can use information-soliciting questions to collaboratively provide clients with an opportunity to make suggestions regarding helpful behavioural changes. In soliciting clients' views on what might be helpful, these questions are highly pertinent to the current proposed in-depth investigation. Ekberg and LeCouteur concluded that these questions led to greater client alignment with the decision-making processes than if the therapist just produced suggestions. However, their focus was on how these questions were positioned in larger sequences of decision-making processes regarding helpful behavioural changes. As a result, there was less focus on comparing different means of designing these questions and associated differences in their sequential trajectories. There is therefore a need for an in-depth investigation focusing on these issues and also one which investigates these similar questions in the context of *Pluralistic Therapy for Depression*.

A final reason for using CA to investigate questions about what might be helpful came from my initial impressions of the first few cases I identified. Clients and therapists in these initial cases seemed to treat these questions as non-straightforward actions. An example of this is shown in Extract TTH (previously discussed in Section 5.2) when the client does not verbally responding to the question, thereby treating it as somehow problematic (lines 34-37). Previous CA studies have indicated that non-straightforward treatment, re-occurring in similar scenarios but across different participants, might highlight some interactional dilemmas being oriented by participants (Ten Have, 2007). Thus, the initial appearance of non-straightforward treatment was another motivating factor for a more in-depth investigation of these questions using CA. If there is evidence that this non-straightforward treatment systematically re-occurs across cases and therapist-client pairs, then the findings will contribute to the project aim of investigating how therapists manage practical dilemmas when engaging in meta-therapeutic talk about methods.

5.5 Inclusion criteria for questions to be investigated using CA

In this section, I will outline the main selection criteria through which I developed and refined a collection of therapists' questions to clients regarding what might be therapeutically helpful. I will illustrate these distinctions using relevant extracts. Mirroring the actual process of refinement, some of the extracts I will discuss contain examples of cases which I eventually excluded from the final collection. Illustrating these excluded cases helps to establish the wider context of the final collection of questions, in terms of variations in how therapists can create opportunities to talk with clients about what might be therapeutically helpful. In this way, the process of refinement through inclusion or exclusion of cases constitutes various empirical observations of how therapists practically manage to create or take such opportunities. These observations illuminate some previously un-described features of creating opportunities for clients to give their views regarding what might be helpful. I will discuss the clinical implications of these observations in Section 5.7.

5.5.1 Criterion 1: Informal and future-focused

These questions were all what I have categorized as informal opportunities for engaging in meta-therapeutic talk about what might be helpful (cf. Chapter Four). This means that they occurred spontaneously in the course of routine talk during the session and not as part of therapist and client discussion of client responses to formal personalisation tools, such as the *Therapy Personalisation Form* (Bowen & Cooper, 2012). The rationale for excluding questions occurring as part of this formal therapeutic activity was based on its appearance as a distinct activity which would thus merit a full CA study in itself. In addition, the data requirements for such a study of formal opportunities extend beyond the data for the current study, since ideally there would be video data to show participants' embodied interactions around these personalization tools.

I also excluded questions focusing on clients' past or present experiences of therapy which were illustrated in Chapter Four. Although these questions could result in talk about what might be helpful, they formed a more indirect route to discussions of what might be helpful. Due to a lack of

existing observational research on meta-therapeutic dialogue, I prioritized focusing on apparently explicit instances of talk about what might helpful in the current project.

5.5.2 Criterion 2: Genuine question with associated interactional constraints

Criterion 2 highlights how included cases must have been treated as genuine questions by clients and/or therapists. A case was considered to be a genuine questions if either the client or the therapist oriented to interactional constraints associated with questions.

I will now illustrate the interactional constraints associated with questions by considering the difference between therapists producing a suggestion, as opposed to a question, regarding what might be therapeutically helpful. From a CA perspective, our classification of these different actions must be evidenced according to how the participants themselves are treating these actions, for example, in terms of what they treat as a relevant next turn from the client (Heritage, 1984). As illustrated by Ekberg and LeCouteur (2014a), this distinction between questions and suggestions can be clearly drawn in terms of the different client responses made relevant by these two different actions. That is, after suggestions the relevant next action for the client is to display agreement or disagreement with the suggestion, whereas after questions the relevant next action is to provide an answer or else an explanation for not answering (Hayano, 2013). Extract HWYL contains some examples which are useful in illustrating this difference between therapists' questions and suggestions. Lines 1-3, 5-6, and 9-10 contain examples of the therapist issuing suggestions regarding what might be helpful, while lines 17-18 and 21 exemplify questions to the client regarding what might be helpful.

Extract HWYL Session#4/Start47minutes/PairA

```
1  T:   ((continuing)) .hh so we ca- we can also make sur#e=at the end of
2       the sessions, th#at we've got time to have a look through: .hh
3       like the genogram. Work as well.
4  C:   Yeah.
```

T: >And maybe until that's: (.) you feel like you've done enough on that?
(.)
C: Ye:[ah]
T: [S:]o: uhm: if that's something we wanna get in as well, I can keep an eye on the time:, .hh
C: Yeah.
T: Uhm and: we can make sure that we: uhm: spend s- fifteen Minutes? Or someth[ing? Or >t]wenty minu[tes (or that)] before
C: [yeah.] [Yeah.]
T: we get to the end?=Does that ↑soun[d (alright).] .h[hh s]o:
C: [Yeah.] [°yeah°]
T: So what do you think. I've been throwing these ideas at you, bu- [(wha-)] how would you like a a session to g[o:.]
C: [Yeah.] [.hh]
C: ↑Ehm
T: >>What would you like me to do more of or less of:.
C: ↑I- (0.3) I- jh ↑realized like (0.3) uhm (0.5) I- t- I kinda felt that ((continues))

In lines 4, 8 and 11, the client minimally responds to the therapist's suggestions but neither the client nor the therapist treat a more substantial response as relevant. This lack of a constraint or requirement for a substantial response is evidenced, firstly, by the client not providing one and, secondly, by the therapist immediately continuing to progress the interaction after the client has minimally responded to their suggestion. Furthermore, in line 17, the therapist explicitly orients to the difference between making suggestions and asking a question to invite the client's own ideas regarding what might be therapeutically helpful: "So what do you think. I've been throwing these ideas at you, bu- (wha-) how would you like a a session to go:" At this point, both client and therapist now treat the client's upcoming response as one which should provide ideas or content in response to the therapist's question. The therapist effects this treatment by leaving space for the client to substantially answer and the client by moving to answer substantially (lines 20, 22).

In summary, the interactions in Extract HWYL illustrate an important difference between how participants treat the therapist's suggestions and questions regarding what might be helpful: Namely, participants treat these actions as making relevant different kinds of responses from the

client. For suggestions, the client need not necessarily do more than minimally respond, whereas with questions, the client is required to provide an answer or, at least, to explain why they cannot provide an answer (Heritage, 1984; Clayman & Heritage, 2002). Questions can thus be considered to be genuine and actual opportunities for dialogue since they constrain the client to substantially respond either by providing an answer or by explaining why they cannot do this. This creates a genuine opportunity for the client to substantially participate in producing content or ideas about what might be helpful.

In all of the cases of questions I selected for further investigation using CA, either the therapist, or else both participants, can be seen to treat the question about what might be helpful as an action to which the client should substantially respond – either by answering or else by explaining why they cannot. As a further, vivid illustration of the response requirements associated with questions, Extract AM shows the client orienting to the possibility of a question from the therapist as something which would constrain the client to respond non-minimally. For several minutes before the extract starts, the therapist has been listing possible therapeutic approaches to the client. This listing continues in lines 1-19. During this activity, the client does not treat it as relevant to do anything more than minimally acknowledge each item (e.g. line 9 "°Right.°"; line 17 "Ri:ght"; line 20: "°Yeah°"). In lines 16 and 18-19, the therapist ends the listing activity by glossing the items as available choices for the client: "WE: can ↑do: a ↓combinat:ion of ↑these ↑thi:ngs:…°Do° different thi:ngs: (.) try=and, look at ↑all of those th↑i:ngs." This summary incorporates a three-part list (1) "↑do: a ↓combinat:ion of ↑these ↑thi:ngs:" 2) ":…°Do° different thi:ngs:" 3) "try=and, look at ↑all of those th↑i:ngs") that further implicates the end of the listing activity (Jefferson, 1990). In line 20, the client minimally acknowledges this summary ("Mm") and a 1.0 second pause ensues. The client then anticipates the posing of a question about what might be helpful by the therapist: ">You're gonna ask me what I< think now ↑aren't yHHouHH" (line 22). This anticipation shows the client treating the therapist's summary and 1.0 second pause as making as making a more

substantial response relevant from the client. Such a substantial response would contrast with their previous minimal responses to the therapist's listing of possibilities.

Extract AM *Session#1/Start13minutes/PairB*

```
T:  .tch .hh eh:m OR: we could use what's known as client
    cent:ered technique of:=you: talking about whatever it is in
    your mind,(1.0) as we go through the sess:ion=
C:  M:m=
T:  =An:d .hhh (0.5) and I try to faCILitate and help you to
    explor:e these issues in greater depth. your↑sel[f. ]
C:                                                   [Ye:]ah
T:  Without using any .hh particular technique or, strategy .shihh
C:  °Right.°
    (.)
T:  .tch .hh >Which as I say< is a <client centered [type] of
C:                                                  [M:m ]
T:  facilitative counselling> typical counselling in actual fact.
    [what  ] °a lot of people would think of as counselling.°
C:  [Ri:ght]
T:  .HH .Shihh OR: WE: can ↑do: a ↓combinat:ion of ↑these thi:ngs:
C:  °Yeah°
T:  °Do° different thi:ngs: (.) try=and, look at ↑all of those
    th↑i:ngs.
C:  Mm
    (1.0)
C:  >You're gonna ask me what I< think now ↑aren't yHHo[uHH  ]
T:                                                   [I'm g]oing
    to ask you if you've got any thoughts ↑yes abou:t
    [whether [you have] a preference:? ↓what you think would be
C:  [HHH     [.shihh  ]
T:  Be[st:: .hhh      ]
C:    [I don't really] have a preference °to be honest° ↑I'm eh:m
    (0.7) [↑I'm- ]
T:        >[There ] ARE, there are some other thoughts actually
    that occur to me. We could< adopt a: a kind of a so↑lution
    focused? approach?
```

The client's anticipation of the potential question here builds on features of the prior interactional context, such as the therapist's summary incorporating a three-part list, which have made it cumulatively more relevant for the client to respond. For our current purposes, we are interested in how the client anticipates a response requirement associated with the potentially upcoming question – that the therapist is going to ask what the client thinks, such that it then becomes relevant for them to respond in a non-minimal, substantial manner: ">You're gonna ask me what I< think now ↑aren't yHHouHH" (line 22). The client here is therefore orienting to a general feature of questions (or information requests), namely that they place pressure on the recipient to respond (Stivers & Rossano, 2010). This pressure derives from constraints on what the recipient of the question does next: the recipient cannot relevantly progress the interaction until they either answer or else provide an explanation for not doing so (Heritage, 1984; Clayman & Heritage, 2002). In either case, the relevant response to a question is a non-minimal one. The client in Extract AM starts to do this in lines 28-29: "°to be honest° ↑I'm eh:m (0.7) ↑I'm-". It is clear here that the client is orienting to the relevance of substantially responding in order to explain why they will not provide an answer to the question.

Extract TTH contains an example in which the client does not substantially respond to the therapist's question. However, this case was included in the final collection, since the therapist demonstrably treats their question as making relevant a substantial response from the client. To illustrate: in Extract TTH (previously discussed in Section 5.2), the client does not immediately verbally respond to the therapist's question. However, in allowing the pause to develop in lines 35-37, the therapist continues to maintain the relevance of the client responding. In line 38, the therapist then explicitly outlines an alternative possibility for how the interaction might progress: "Or I could tell you my thoughts". In prefacing this alternative possibility with "or", the therapist also orients to the possibility made relevant by the initial question, which was for the client to substantially respond in a non-minimal manner by detailing "thoughts". Thus, in Extract TTH, even though the client does not initially verbally or substantially respond to the question, we can see how

the therapist still orients to the relevance of the client doing so, firstly, by allowing the pause to develop and, secondly, by therapist's explicit outlining of an alternative way to progress the interaction.

Appendix D contains the full set of cases in the collection with annotations showing the evidence for how each case fulfilled this selection criterion whereby either the therapist or else both participants demonstrably treated the therapists' turn as making relevant a substantial response from the client, either in the form of an answer or else or an explanation as to why they could not answer. This criterion was essential, since it ensures that all cases in the final collection are indeed instances in which the therapist created a genuine opportunity or relevance for the client to substantially participate by answering question and giving their views about what might be helpful – as opposed to just an apparent or somehow ambiguous opportunity.

Extract I1 contains such an ambiguous example which was excluded from the final collection. Here the therapist takes a turn which has the grammatical form of a question (line 6: "↑ho:w is it possible to dim that switch."), but neither client nor therapist demonstrably orient to the relevance of the client responding more than minimally (Cantwell et al., 2017). For example, the client provides minimal acknowledgements in lines 8 and 14, but does not otherwise respond to the therapist's turn. The therapist's actions here are certainly pursuing a response from the client. For example, they leave pauses in line 7 and line 9, which create a relevance for the client to respond. In addition, when the client just minimally responds to the initial turn in lines 4-6, the therapist then issues what looks like a subsequent version of this turn in lines 10-12. Such a subsequent version after the client has already had an opportunity to respond shows that the therapist is pursuing a more extended response from the client (Davidson, 1984). However, the therapists' turns themselves are ambiguous in terms of what kind of a response they make relevant from the client. On the one hand, lines 4-6 can be seen as a grammatically complete question and lines 10-12 as a subsequent pursuit of that question. On the other hand, lines 4-6 can be seen as an interpretation displaying the therapist's perspective and lines 10-12 as pursuit of extended agreement from the

client to this interpretation (Bercelli et al., 2008). The client may be exploiting this ambiguity by not treating these turns as questions to which they have to respond in a more than minimal fashion. In line 15, the therapist produces an increment to their previous turn, which is another form of pursuit (Bercelli et al., 2008; Ford, Fox & Thompson, 2002; Pomerantz, 1984a). The therapist's increment displays a confirmatory stance regarding their prior talk: "Because it does feel like a game. And it does feel like,", which shows them now demonstrably treating their previous turns as also having been interpretations. On this basis, this case was excluded from the final collection, since neither participant has treated the therapist's turns in lines 4-6 and lines 10-12 as unambiguously posing a question to the client regarding their views.

Extract I1 *Session#6/Start43 minutes/PairC*

```
1   C:   ((continuing)) but >I'm the (bigge)- I'm the one that's:< that
2        <°can't=help myself.°>
3        (2.5)
4   T:   pt Well I GUESS, in terms of helping yourself the question
5        ↓there I mean it feels like the place we got to is .hh how did
6        (.) ↑ho:w=is- ↑ho:w is it possible to dim that switch.
7        (0.5)
8   C:   °Yeah°
9        (0.5)
10  T:   How is it possible to just dim it, (.) turn the lights down
11       (.) e:nough (0.7) so that you're just not caught up in that
12       ↑game all the time.
13       (.)
14  C:   Yeah
15  T:   Because it does feel like a game. And it does feel like, .hh
16       u:h (0.4) that- kinda tapping on your shoulder and prodding is
17       not massively helpful.
```

In summary, Criterion 2 ensures that, in all cases in the final collection, either the therapist or else both participants demonstrably treated the therapists' turn as making relevant a substantial response from the client. And that this substantial response took the form of an answer or else or an explanation as to why they could not answer. Criterion 2 thus enables that claim that in all cases in

the final collection, the therapist created a genuine and non-ambiguous opportunity or relevance for the client to substantially participate in talking about what might be helpful by answering and giving their views. Criterion 2 also extends the rationale for excluding therapists' suggestions from the current study, since these do not afford such a clear relevance for the client to dialogically participate by sharing their views about what might be helpful.

5.5.3 Criterion 3: Invites client to independently produce content

Criterion 2 illustrated how an essential difference between questions and suggestions pertains to the differing interactional constraints imposed by these actions on how the client can respond. A second important difference between questions and suggestions relates to who is producing the content or ideas regarding what might be therapeutically helpful. In Extract HWYL (previously discussed in Section 5.5.2), the therapist explicitly orients to the difference between questions and suggestions when they say: "So what do you think. I've been throwing these ideas at you, bu- (wha-) how would you like a a session to go:" (lines 17-18). With suggestions, the therapist presents "ideas" or content to the client, whereas with questions, the therapist invites the client to independently produce content regarding what might be helpful in order to non-minimally and substantially respond to the question (Ekberg & LeCouteur, 2014a).

Extract HDTS provides an illustration of how the therapist can make it more relevant for the client respond to content produced by the therapist. In this case, the therapist issues a response solicitation in the form of a question (lines 9, 11: "↑how- well ↑how does that sound as an idea:") specifically inviting the client's views regarding a suggestion the therapist has been developing just previously (lines 2-5, 7, 9). The therapist's question here displays that that the client has some discretion regarding to what extent they might accept this suggestion (Ekberg & LeCouteur, 2014b). In explicitly inviting the client's views, this can be considered a dialogical opportunity, created by the therapist. This is since the question unambiguously makes it relevant for the client to substantially respond more than minimally to the therapist's suggestion. However, questions like the one in

Extract HDTS were excluded from the final collection. The rationale for this exclusion is outlined in the following paragraphs.

Extract HDTS *Session#8/Start14minutes/PairA*

```
 1  C:    =Y#eah=
 2  T:    =Ho:w- >we can have a think about< how could we explore .hh
 3        what happ#en:ed .h ↑uhm (.)for yo#u: or: what you feel .hh
 4        °#e:-° you know=how you think=feels- (.) things might be (.)
 5        different or[: ] .hh uhm: (0.5) .pch what you'd want to say
 6  C:                  [Ye]ah.
 7  T:    to:: .hh uhm:
 8  C:     ↑↑Ehm-=
 9  T:    =your ex about it or [you can] like [(wel-)] ↑how- well ↑how
10  C:                         [Ye:ah. ]      [Ye:ah.]
11  T:    does that sound as an idea:.=
12  C:    =Yeah 'cause you were saying about writ#i:ng (.) uhm: (0.3) a
13        letter inn[i:t?   ]
14  T:              [(Yeah.)] yeah ye:ah=
```

This point regarding who is producing content regarding what might be helpful illustrates the different ways in which the therapist can create dialogical opportunities. As we have seen, suggestions enable the therapist to present content to the client. The client can then minimally respond to show agreement or they can also respond more substantially to explicitly evaluate the content of the therapist's suggestion. In either scenario, the client is still responding to content the therapist has produced rather than independently producing their own content regarding what might be therapeutically helpful. In contrast, it is also possible for the therapist to invite the client to independently produce content regarding what might be therapeutically helpful. After noting and elucidating this distinction regarding who produces the content about what might be helpful, I excluded cases, such Extract HDTS, in which it is primarily relevant for the client to respond to content by produced the therapist. The overarching rationale for this decision was my assessment that questions which invite the client to independently produce content are more dialogical than those where client is invited to respond to content produced by the therapist.

This evaluation that questions inviting clients to independently produce content are more dialogical was based on the following reasons. Opportunities in which content produced by the client is foregrounded may be considered more dialogical due to pervasive asymmetries in perceived authority and expertise between the client and therapist. Some clients may be initially reluctant to volunteer content due to deference the therapist (Rennie, 1994; Cooper & McLeod, 2011). Or perhaps, in the early stages of therapy, the client's "voice" and ability to articulate their needs is "weak" and requires encouragement and exercising (McLeod & Cooper, 2012). In inviting the client to independently produce their own ideas regarding what might be helpful, the therapist *structures* and endorses the *immediate* therapeutic relevance of the client to participate equally in suggesting helpful approaches and activities (Leudar et al., 2008).

Furthermore, it can be assumed that questions explicitly inviting the client's own ideas regarding what might be helpful are less likely to be pursuing the client's agreement with content produced by the therapist. In contrast, in certain contexts, even a response solicitation like "↑how does that sound as an idea:" may be a means of pursuing or imposing agreement rather than creating a dialogical opportunity. Finally, questions which explicitly invite clients for their views regarding what might be helpful encourage a focus on the client's existing resources and expertises, thus framing meta-therapeutic dialogue as a mutual endeavour and partnership between client and therapist (McLeod, 2013).

In summary, I excluded cases from the final collection in which it was primarily relevant for the client to respond to content produced by the therapist. This decision was taken in light of the evaluation that questions which made it relevant for the client to independently produce content appeared *prima facie* to be more dialogical opportunities.

5.5.4 Criterion 4: Does not pursue client to fill in therapist-prescribed solution slots

In our examination of Criteria 2 and 3, we have explored how questions included in the final collection required evidence that the clients and therapists indeed treated them as genuine

questions with the associated interactional constraints (Criterion 2) and that the question asked the client to independently produce content about what might be therapeutically helpful (Criterion 3). I have argued for the relevance of these criteria on the grounds that they contribute towards specifying a collection of cases of highly dialogical opportunities. However, when initially gathering cases, I noticed that therapists can also ask questions which appear to invite the client to independently produce content while also specifying what I am calling a *solution slot* into which the client should fit this content. Although these questions initially appeared to be dialogical opportunities, I nonetheless decided to exclude this group of questions due to some less dialogical, and indeed, potentially coercive, features which became apparent upon closer analysis.

In what follows, I will provide some examples to evidence this decision to exclude questions which included solution slots. First I will present an excluded case. Then I will present a borderline case, which contains a solution slot but which I nevertheless decided to include given evidence that both participants nevertheless treat this question as a dialogical opportunity.

Extract NQA shows a case I excluded. Here, what I am calling the actual *solution slot* is produced by the therapist in lines 17-18: "what would be a good wa:y of thinking about yourself so that could be: replaced". The rationale for the solution slot has been developed by the therapist from lines 5 onwards and, in particular, after they have completed a concession to the client in line 6 ("I mean th=that really makes sense what you were saying about…").

Extract NQA *Session#16/Start33minutes/PairD*

```
 1  C:   ((continuing)) >And my self< (.) wor:th .h eh:m, (5.8)
 2       I don't kno:w, do I need to: (1.8) try and take those
 3       feel#i:ngs into other p#arts of my
 4       #life .hhh [(↑No::) ]                    [KHeM     ]
 5  T:              [Well I G]UEss the qu- I guess [the quest]ion for
 6       me: would (.) >I mean th=that really makes sense what you were
 7       saying about that gives you me:aning .hh but al:so, °i- I- i-°
 8       it feels sad in a way I guess that ther- there's- (.) there's
 9       that kinda underly:ing, (0.6) I-  (0.3) I'm not a good person.
10       (0.3)
11  C:   M:h[m]
```

12 T: [I] don't deserve things which: >f:eels like something you
13 can kind of fall back into< (0.4) and kinda come back to if
14 you're not doing things that do feel ↓good.
15 C: Yes- ye[:ah.]
16 T: [And]I- guess- question for me would be: (0.4) I
17 wonder <what that cou-> what would be a good wa:y of thinking
18 about yourself so that could be: replaced
19 (0.6)
20 T: InSTEAD of thinking I'm not a good person, I ↓don't deserve
21 °things° .hh how would you li:ke, wha- ↑what would make sense.
22 (1.0)
23 T: .tch Because it might not be: (0.5) °you kn~ow° I'm a
24 w#onderful pe#rson and I des#erve the univ#erse and- .hh °you
25 know° but I wonder what would be a kind of: (1.7) a w#ay of
26 thinking about your°self°
27 (9.7)
28 C: °I don't kno:w=I don't think there ↑is any,° (1.3) °quick
29 answer to tha[t.°]
30 T: [We]ll maybe it's ↓something to: °>(have a)<°
31 think abou:t.
32 C: Uhuh
33 (1.7)
34 C: °Ehm° (1.7)
35 T: .SHIH Because it DOES feel like >°what you've been describing°<
36 ((continues))

Notably, the therapist's lead up to, and production of, this solution slot offers no opportunity for the client to directly evaluate the content the therapist has been producing. Instead, the question just requires the client to fill in the details of the solution slot by suggesting a "good wa:y of thinking" to replace the problematic way of thinking. If the client were to provide such content, then they would be implicitly endorsing both the content of the solution slot and its positioning at this particular point in the session. In Extract NQA, the client does not move to provide the requested content even though the therapist leaves plenty of interactional space for the client to do so in lines 19, 22 and 27. In the absence of a verbal response from the client, the therapist moves to *pursue* one from the client using a script proposal (lines 20-21: "I'm not a good person, I ↓don't deserve °things°") (Emmison, Butler & Danby, 2011). This script proposal involves speaking in the client's voice and thus frames the solution slot as being based in the client's own talk, which makes it more difficult to

interactionally resist (Ekberg & LeCouteur, 2014a; Emmison, Butler & Danby, 2011; Land, Parry & Seymour, 2017; Sandlund, 2014).

The therapist also pursues by producing a subsequent version of the question in lines 23-26 (Davidson, 1984). Even when the client responds by disputing the presupposition that that this is a solution slot which can be filled immediately (lines 28-29: "I don't think there ↑is any,° (1.3) °quick answer to that°"), the therapist still suggests that filling the solution slot is a worthwhile activity (lines 30-31: "Well maybe it's ↓something to: °>(have a)<° think abou:t.").

The interactions in Extract NQA show the therapist engaging in vigorous pursuit when the client does not produce the content to fill the solution slot. In refraining from responding for long periods of time (lines 19, 22 and 27) and, subsequently, in disputing that this solution slot can be filled immediately (lines 28-29), the client observably misaligns with the therapist's question action agenda. However, the therapist responds to this misalignment by further pursuing the client's production of content to fill the solution slot. Notably, this pursuit occurs in a context where the therapist has not given the client the opportunity to explicitly accept or reject this solution slot in the first place. Furthermore, the therapist's continued *pursuit* of an answer from the client when the client is interactionally resisting doing so renders the question less dialogical and may be treated as interactionally coercive (Land, Parry & Seymour, 2017). On these grounds, I excluded Extract NQA and similar cases similar to this from the final collection of questions comprising opportunities for meta-therapeutic dialogue.

Extract WITBR contains an example of a borderline case in which the therapist presupposes acceptance of the solution slot provided by the question but which was included in the current study. In lines 2-3, the therapist initially foregrounds the client's critical voice by explicitly asking the client to confirm a formulation "because you've had no experiences=is that what it's saying". The client initially answers the therapist's query in lines 5-11, before gradually shifting from the critical voice to a focus on the client's goals more generally, for example, "I wanna be kind of happy=but" (line 21).

Extract WITBR *Session#3/Start35minutes/PairC*

```
1         (1.0)
2   T:    .HH But THAT voice is saying you're nothing because:, (.)
3         you've had no °exp↑eriences?=is that what it's saying?°
4         (.)
5   C:    In a way, but- I'm nothing because: I °am nothing,°
6         (0.6)
7   C:    I probably haven't had (.) enough exp#eriences or whatever.
8         (0.8)
9   ?:    .hh
10  T:    Yea:h.
11  C:    To, (0.7) (cloud) over or cover it.
12        (0.9)
13  C:    °(An')° (.) °>what I see as, (1.0) a bit of (pool shark),
14        (0.5) something just to keep my life, (0.7) living.
15        (0.9)
16  C:    Someone to (treat) you=↑ah that l↑ooks good >↑oh somebody
17        likes me=or loves me? [°(you know the way< or)] whatever,°
18  T:                          [Yea:h.                ]
19        (2.4)
20  C:    But, (.) I suppose, (1.4) ((movement during pause)) ↓maybe, (3.0)
21        °I wanna be kind of happy=but.°
22        (0.9)
23  T:    What's the best ar:g- I mean when that voice says (.) you're
24        ↓nothing, (0.5)
25  C:    °Uhuh.°
26  T:    .hh wha- what is the best response to that.
27        (1.7)
28  C:    °I don't have a response to it=that's the thi[ng° I just]
29  T:                                                 [Nyea:::h  ]
30  C:    agree with it.
31        (0.4)
32  C:    THAT'S THAT'S PROBably:, .hhh (1.0) °that is the answer .pch
33        or not the answer the question,=
34  T:    =NO:=(>>I think<<)=you are=I think that's- that- in a
35        way=that's the core of the problem isn't it.
36        (1.3)
37  T:    I mean that's a core >of it< i:f we can work ou:t,
38        [how you [respond   [to that[voice,]
39  C:    [It's j- [it's just [too    [it's   ]:: hh (0.5) HH just go
40        yea:hh I can hear you, (0.4) but, (.) I'm gonna do:
41        ((continues))
```

In lines 23-24 and 26, the therapist then shifts the focus of the talk back to the critical voice by posing a question, "…when that voice says you're nothing, what is the best response to that". This question focuses on what might be therapeutically helpful for the client. Importantly, the question achieves this focus by embodying the presupposition that brainstorming the "best response" will be helpful for the client at this point. This presupposition is all the more noticeable given how the client had moved away from a focus on the critical voice in their just-prior turn. Furthermore, the question does not provide space for the client to consider whether this particular strategy of brainstorming, and indeed, whether focusing on this strategy at this point in the session, might be helpful. Instead, the question only makes it relevant for the client to consider what "the best response" might be. We can therefore see how this question about what might be helpful in Extract WITBR initially appears dialogical since it invites the client to give ideas as to a "best response". However, upon further analysis, it is also clear that the therapist creates this apparently dialogical opportunity having already presupposed and pre-selected what they perceive to be a currently helpful focus and strategy, namely brainstorming what "the best response" might be. In this sense, the therapist can be seen to use the question to ask the client to fill in the details of a *solution slot* which the therapist has constructed.

In Extract WITBR, the client does align with the topical focus of the therapist's question on "the best response" by first describing how they "don't have a response" and then subsequently affiliatively endorses this focus as important, "that's the thing" (line 28). So, although the focus and solution slot have been unilaterally introduced by the therapist, the client here aligns by maintaining and endorsing the focus on this task of considering what might be "the best response". This alignment by the client validates the question's focus and thus facilitates the talk to proceed in a dialogical manner with both client and therapist moving to further contribute talk about a "best response" (lines 32-41). In this way, the solution slot proposed by the therapist in the question is endorsed and treated by the client as a dialogical opportunity such that it is unnecessary for the therapist pursue the client's participation in filling the solution slot. This lack of pursuit from the

therapist can be considered a dialogically essential feature in such cases, since the therapist has not otherwise given the client the opportunity to explicitly consider the suitability of this particular solution slot. On these grounds, I retained WITBR and similar borderline cases in the current collection.

5.5.5 Criterion 5: May be process-focused or more specifically-focused

The selection criteria for questions included in the final collection were inclusive of a range of topical foci. As long as the question asked the client what would be helpful regarding some topical focus, then this question was considered a candidate for inclusion in the collection. This included questions with a more general focus on how helpful the client was experiencing the overall therapeutic approach, activities and processes, as well as questions with a more specific focus on what might be helpful regarding a specific problem or in reaching a particular solution or goal. I will now illustrate each of these types of question.

Questions that elicit clients' views on the general helpfulness of overarching therapeutic approaches and activities can be considered to be more process-focused, with an emphasis on establishing, renewing or adjusting what the therapy should consist of (Lee, 2006) (cf. Chapter Two). For example, in Extract TTH, the therapist simply poses the question to the client as to what they would like to "do" in the sessions: "…IN TERMS of the THERapy here< what's what's your: sense of it… what's your thinking about what you'd like to °do°" (lines 31-33). The more process-focused questions in the collection also include feedback questions inviting the client to make suggestions for improving or adjusting the sessions. For example, in Extract HWYL (presented earlier in Sections 5.5.2 and 5.5.3), the therapist asks the client how they would like a session to go: "So what do you think. I've been throwing these ideas at you, bu- (wha-) how would you like a a session to go:" (lines 17-18). The topical focus of these process-focused question is wide-ranging and refers more to the overall process and activities of the session as opposed to being focused on what might be helpful for the client regarding a specific problem or goal.

More specifically focused questions were also included in the final collection. These focused on what might be helpful around a specific problem or goal. For example, in Extract SC1 (section 5.2), the therapist asked the client what might help them to "move on" after years of focus on a missing loved one (line 5). The client's previously stated goal in this set of sessions had also been to "move on", so the therapist here can be seen to open a discussion regarding the kinds of therapeutic activities that might be helpful for the client in working towards this specific goal. This kind of future-oriented question eliciting the client's suggestions for working towards a specific goal can be categorized as a *solution-focused question* (Molnar & Shazer, 1987; Stokoe & Sikveland, 2016). Indeed, two minutes before posing this question, the therapist had announced a shift to "applying: a s:ort of solution focused lens" to the talk about the client's difficulties in the current session. The client had also decided on a solution-focused approach as their preferred therapeutic approach in an earlier session with the therapist. Thus there is evidence that some therapists orient to these questions focused on what might help with specific difficulties and issues as a solution-focused approach (Molnar & Shazer, 1987).

Extract HWT contains another example of another therapist posing a question regarding what might help the client regarding a specific difficulty, although a solution-focused approach or problem-solving approach was not explicitly decided upon by this client-therapist pair. Prior to the beginning of the extract and in lines 1-7, the client and therapist have been exploring the client's difficulties in sleeping. In lines 8-9, the therapist then asks the client what "would help with" these difficulties. In lines 12-13, the client starts to answer this question.

Extract HWT *Session#9/Start2minutes/PairE*

```
1   T:    Eh khem (.) so but (0.3) it seems like your: (0.5) sleep is
2         related to not (.) liking the dark?
3         (2.0)
4   C:    Yeah.
5   T:    °Okay.°
6         (0.4)
7   C:    °I think so.°
```

T: °Mhm° .hh ↓is there anything you can do that would help with that.
(0.5)
T: [Like]
C: [.hh] Ehm, .hh H I've been doing like, (.) audios you g#et on the internet for like s#ort of relaxing, ((continues))

In summary, the final collection of cases includes both questions which are more process-focused regarding what might be generally helpful across all goals and questions which focus on the helpfulness of one specific issue or goal or solution. The process-focused questions make it relevant for the client to produce content regarding overall therapeutic approaches, activities, processes and methods. In contrast, the more specifically-focused question work to elicit ideas around methods which might be helpful in reaching a specific goal or managing a specific problem. As outlined in Chapter Two, these more specifically-focused questions might be considered *solution-focused* if they focus on expanding on possible solutions or *problem-solving* if the focus is on foregrounding the details of a problem with a view to solving it using these details (Jordan, Froerer, & Bavelas, 2013). As we have seen, there is endogenous evidence from one therapist-client pair that more specific questions about what might be helpful were considered to be more solution-focused. However, others therapists also pose such questions without having explicitly agreed upon a solution-focused or problem-solving approach with the client.

The decision to include both process-focused and more specific questions about what might be helpful was based on several considerations. First, both question types invite the client to contribute ideas or content regarding what might be helpful. In this sense, both types are potentially dialogical since they create opportunities for clients to participate in shaping the therapeutic methods and activities by contributing their knowledge. Second, participants overwhelmingly treated both questions types as non-straightforward to pose and to respond to. It therefore seemed likely that participants might face some of the same considerations and dilemmas for both. A third factor contributing to the decision was the pragmatic consideration that these questions appeared,

from the outset, to occur quite infrequently. However, given their initial appearance as offering highly dialogical opportunities, it seemed important for the collection to be inclusive of all such apparent opportunities. Finally, the distinction between process-focused and more specifically focused questions about what might be helpful is not explicitly referred to in the pluralistic therapy literature. However, Papayianni and Cooper (2017) specified how MTC could also relate to *extra-therapeutic activities*, that is, client activities done outside of the therapy sessions. It is possible that this previously implicit distinction between more process-focused and more specific questions about what might be helpful may have relevance for pluralistic therapy and training. The conceptual and clinical implications for this issue of a possible solution-focused or problem-solving flavour to meta-therapeutic talk about therapeutic methods will be discussed in Section 5.7 of the current chapter.

5.6 Frequency of cases across client pairs in the current sample

Twenty eight cases of questions about what might be therapeutically helpful were identified using the inclusion criteria outlined in the previous section. Table 1 indicates how frequently these questions occurred across the seven pairs, and also, within the six sessions sampled for each client-therapist pair. They occurred in 16 of the 42 sessions sampled (cf. Chapter Three for more details regarding session sampling).

Questions about what might be therapeutically helpful are posed by therapists across pairs, as evidenced by their occurrence in six out of seven pairs in the current sample. However, the amount of questions varied widely across and within pairs. 15 of the 28 cases occurred in the sessions of the qualified therapist who was sampled across three pairs (Pairs B, C, and D). Pair B produced 12 questions about what might be helpful, which is more than double the total amount for any other pair. For Pair B, 10 of these occurred in just two sessions, indicating that some occasional sessions can have more questions about what might be helpful than others. As detailed in Chapter Three, the therapist in Pair B is also the therapist for Pair D. However, there were no questions about what might be helpful in the sessions sampled for this pair.

When therapists did pose a question about what might be therapeutically helpful in a session, the average point of first occurrence was 25 minutes into the session (SD = 14.8). In six sessions, therapists posed >1 such question. The majority (approximately 80%; n=22) of questions about what might be helpful specifically focused on the client's ideas regarding a particular issue or goal, with the remaining group of questions (n=6) inviting the client's ideas regarding the therapeutic approach generally.

Table 5.1: Frequency of questions about what might be therapeutically helpful across sessions and within client-therapist pairs

Therapist	Pair	*Session Sampled* #0 **	#1	#2	#3	#4	66.6% ***	Alternative ****	Alternative ****	TOTAL
1	A	X *	2	2	0	X *	0	0 #5	0 #6	4
2	B	1	0	6	1	X *	4	0 #6	-	12
2	C	1	X *	2	0	X *	0	0 #8	0 **#14**	3
2	D	0	0	0	0	0	0	-	-	0
3 $	E	0	1	0	2	1	0	-	-	4
4 $	F	X *	0	0	0	0	1	0 #5	-	1
5 $	G	1	0	1	0	1	1	-	-	4
TOTAL questions *(no. of sessions sampled)*		3 *(5)*	3 *(6)*	11 *(7)*	3 *(7)*	2 *(4)*	6 *(7)*	0 *(4)*	0 *(2)*	**28** *(42)*

* X = session not available for sampling

** Session #0 = assessment session

*** 66% = session at point of 66.6% completion

**** Alternative = session sampled to replace unavailable one

$ = trainee therapist

5.7 Discussion

In this chapter, I have demonstrated how the finalized selection criteria give rise to a collection of questions which invite the client's own ideas about what might be therapeutically helpful. I have also presented frequency data for cases in the final collection. Furthermore, I have presented arguments from the clinical literature and CA-based evidence as to why these selection criteria result in a collection of opportunities for meta-therapeutic dialogue, which it will be informative to investigate using Conversation Analysis. The clinically-based arguments are largely derived from the

dialogical significance of opportunities in which the therapist uses questions to invite the client to give their own ideas regarding what might be therapeutically helpful. Given the likelihood of asymmetries of perceived authority and expertise regarding what might be therapeutically helpful, I have also argued that these opportunities in which the client's own existing knowledge and preferences are made relevant are more dialogical than those in which the client is being asked to respond to the therapist's ideas regarding what might be helpful.

Cases in the final collection all fulfil the following inclusion criteria: the questions are informal opportunities for meta-therapeutic dialogue arising spontaneously in from participants' talk in the session; furthermore the questions are future-oriented (Criterion 1); the questions are genuine opportunities for dialogue, as demonstrated by participants demonstrably orienting to the interactional constraints associated with questions (Criterion 2); the questions invite the client to independently produce content or ideas regarding what might be helpful (Criterion 3); the questions *do not* work to pursue clients to fill in the details of particular solution slots prescribed by therapists (Criterion 4); the topical focus of the questions varies in specificity and can be regarding the general therapeutic approach or a specific issue or goal (Criterion 5).

The final collection of questions about what might be therapeutically helpful indicates the infrequency of their occurrence in the current sample of 42 sessions of pluralistic therapy. Due to the small number of sessions sampled and the small number of questions in the final collection, we cannot generalise about the probability of this infrequency reoccurring in other samples. However, the fact that these apparently highly dialogical opportunities occur so infrequently in the current sample further adds to the rationale for exploring them more in-depth using CA. The in-depth CA investigation in Chapters Six through Eight will indicate some possible factors which might be contributing to this infrequency of occurrence.

5.7.1 Conceptual issues arising for MTC regarding therapeutic methods

The distinction highlighted in Criterion 5 between process-focused questions regarding the general helpfulness of the therapeutic approach and methods and questions more specifically-focused on

particular issues or goals is not explicitly referred to in the pluralistic therapy literature. The current chapter highlights how the more specific questions can be categorized as solution-focused or as problem-solving. As detailed in Section 5.6, these more specific, solution-focused questions are more numerous in the final collection. One possible explanation for this finding is that there are aspects of pluralistic therapy which, in practice, are highly similar to solution-focused therapies (e.g. Molnar & de Shazer, 1987) or perhaps like other problem-solving or problem-management approaches such as CBT (e.g. Blackburn & Davidson, 1990). Following this line of thinking, what has been termed *meta-therapeutic dialogue* might inevitably involve solution-focused or problem-management concerns in exploring what is helpful in facilitating a client to reach their goals.

McLeod & Cooper (2012) list *structured problem-solving* as a common therapeutic method which might be used in pluralistic therapy. However, the possibility being raised by the current chapter is that *structured problem-solving* is more than just one of many possible therapeutic methods in pluralistic therapy and actually also forms the basis of meta-therapeutic dialogue. If this possibility holds fast, then it might be that the technical eclecticism of pluralistic therapy stops when *meta-therapeutic dialogue* begins, since meta-therapeutic talk essentially consists of problem-solving or solution-focused talk. The issue of some similarity between the concrete practice of meta-therapeutic dialogue and problem-solving will be further explored in Chapter Six.

If it were the case that pluralistic therapy presumed that all clients wanted to reach therapeutic goals, then it would certainly be true that clients would be un-pluralistically shoehorned into a one-fits-all solution-focused or problem-solving approach. However, the developers of pluralistic therapy acknowledge that there needs to be due consideration and space in pluralistic therapy for those clients who may not be able to articulate or work towards goals at any particular point (Cooper & McLeod, 2011). Indeed, the empirical observations in the current chapter provide evidence that pluralistic therapy is implemented differently across different therapist-client pairs. For example, questions about what might be therapeutically helpful were variously dispersed across therapist-client pairs and there were no or very few such questions occurring in the talk of some pairs. Therapist 3 is a vivid illustration of this, since they posed no questions about what might be

therapeutically helpful in one pair, but a relatively high number in another pair. This variation may show responsiveness by the therapist to each individual client and, if further evidenced, would provide a snapshot of therapy personalization-in-action and furthermore might constitute evidence for an adherence measure for pluralistic therapy. This issue of therapist responsiveness will be discussed again in relation to the findings of Chapter Eight.

Moving on now to consider how the relationship of the findings in the current chapter to existing research, Papayianni and Cooper (2017) found that therapists' post-session notes from the Cooper et al. (2015) *Pluralistic Therapy for Depression* study most frequently focused on meta-therapeutic dialogue regarding the topical categories of *Current Session* or the *Therapeutic Work as a Whole*. This would appear to contrast with the finding that more specific questions outnumber more general, process-focused questions. For several reasons, it is difficult to compare the current findings based on the same Cooper et al. (2015) study to Papayianni and Cooper's findings. First, Papayianni and Cooper employed topical codes which may not be commensurable with the current study. For example, it is possible that the distinction I have made between more generally-focused and more specifically-focused questions about what might be helpful would be partially or fully encompassed by the code *Therapeutic Work as a Whole*. This is since questions about what might be helpful which relate to a specific goal could still feasibly be counted as relating to the *Therapeutic Work as a Whole*. A second reason as to why the results are difficult to compare concerns how the current study focuses only on therapist's questions inviting clients' own ideas regarding what might be helpful and, thus, not on other forms of meta-therapeutic dialogue (e.g. those illustrated in Chapter Four) such as therapists' suggestions. A third reason for the difficulty in making comparisons relates to the smaller number of sessions sampled in the current study compared to the number sampled by Papayianni and Cooper. Finally, the post-session notes sampled by Papayianni and Cooper study are limited as a form of data in terms of summarily reducing the session interactions and being reliant on how therapists prioritized, remembered and described these interactions.

These difficulties in comparing the studies raise some important methodological issues for future studies investigating meta-therapeutic talk. These include whether the data should

observational or based on self-reports or include both data types and any practical constraints in how many recordings can be surveyed. There is also the more general issue as to whether it is clinically useful to focus research on the topics of meta-therapeutic dialogue without also detailing the interactional features of this, since, as illustrated in the current chapter, it is possible for therapists to deploy what is ostensibly meta-therapeutic talk in more and less dialogical ways.

5.7.2 Clinical implications

I will now discuss some clinical implications of the empirical observations underpinning the development and refinement of these selection criteria.

The issues highlighted in the illustration of Criterion 2 show the therapeutic importance of considering the differing sorts of response spaces for clients, made relevant by different therapist actions. As we have seen, with questions, the client is interactionally constrained to either provide a substantial answer or else to explain why they cannot answer, whereas the client is not constrained to do so when responding to suggestions. In addition, suggestions are directive towards particular actions that the client could take, since they inherently involve the therapist endorsing the content of the suggestion (Ekberg & LeCouteur, 2014a; Pilnick, 2004; Toerien, Shaw & Reuber, 2013). These different response spaces created by therapists have implications for how much the client is substantially involved in talk about what might be therapeutically helpful. This is highly relevant for the practice of pluralistic therapy, since the approach emphasizes mutual, two-way, dialogical discussions when evaluating and selecting different therapeutic activities and approaches. The current findings show that suggestions from the therapist can result in less two-way talk between client and therapist regarding what might be helpful and in less client talk regarding what might be therapeutically helpful. This implies that incorporating an explicit distinction between questions and suggestions in pluralistic training may be beneficial in terms of sensitizing practitioners to the different possible interactional outcomes of using suggestions versus using questions.

In illustrating Criterion 3, I distinguished between questions which invite the client to independently produce content or their own ideas about what might be helpful and questions which

invite the client to respond to content the therapist has produced. As outlined earlier in this chapter, Criterion 3 derives from the adoption of a strengths-based approach in pluralistic therapy. This advocates incorporating clients' existing knowledge, coping skills and idiosyncratic resources into meta-therapeutic discussions. From a clinical perspective, there is a substantial difference between creating opportunities for the client to independently produce their own content versus opportunities for the client to respond to content produced by the therapist. Both opportunities are indeed dialogical and demonstrate a prioritization of the client's perspective; nonetheless, the former opportunity comprises a more pronounced valuing of the client's expertise, as advocated by the resource-oriented approach endorsed in pluralistic therapy (e.g. McLeod, 2013). Chapters Six through Eight will detail some complexities in therapists' bids to follow a resource-oriented approach. However, even at this point, it is clinically important that therapists are aware of this distinction between inviting client's own ideas and inviting clients' views on therapists' ideas when engaging in meta-therapeutic dialogue.

Criterion 4 requires that the questions in the final collection for the current study *do not* work to pursue clients to fill in the detail of solution slots created by the therapist. The excluded case demonstrates how questions can *appear* dialogical in terms of inviting clients to give their own ideas regarding what might be helpful, when actually the questions are working to secure the client's acceptance of a solution slot being advanced by the therapist. As such, this practice of asking the client to fill in the details of a pre-prepared solution and not also asking about the suitability of the presupposed solution itself might be considered, at best, superficially dialogical and, at worst, interactionally coercive. In direct contrast, pluralistic therapy advocates that therapists need to make sure they create opportunities for clients to give their views on the overall therapeutic approach and general strategies, as well as the actual details. This illustration serves as an important reminder for practitioners to be mindful of the presuppositions about solutions contained in their questions and of how clients are receiving them. These considerations around Criterion 4 also highlight how dialogue is inherently a two-way process. The talk can progress very differently depending on whether the client aligns with the presuppositions in the therapist's question and

depending on how much space the client is given to do this (cf. Extract WITBR vs. Extract NQA). As we have seen, there is a danger that pursuing the client to quickly fill in the details can become a monological and somewhat coercive action by the therapist, particularly if the client is observably resisting.

The illustrative cases used to evidence Criterion 4 can additionally practically function as reflective prompts for practitioners and trainees. Such reflections could focus on what kind of factors might be influencing the therapist's continued pursuit of the client's ideas for filling the solution slot, given the client's observable resistance to doing so. For example, pursuing ideas from clients to fill in the detail of a solution slot is one way therapists can implicitly secure clients' acceptance of a particular therapeutic strategy. If the client complies by filling in the details, this means the therapist can avoid explicitly checking whether the client is on board with this particular strategy. Some therapists may engage in such avoidance due to the risk that the client will reject this strategy if they are given an opportunity to explicitly consider whether it might be helpful at this point. Various factors could underlie this avoidance for different therapists at different times. For example, a therapist might feel anxious or unsure regarding how else they can support this particular client or perhaps a therapist is feeling some frustration towards the client or perhaps they are succumbing to an urge to rescue the client or perhaps they see themselves as challenging the client as this particular point. Exploring the private psychological motivations for actions goes far beyond the realm of CA research. However, as with the findings from the current chapter, CA research can provide real-world therapeutic material which therapists can then explore more subjectively. For example, as advocated by Means and Thorne (2007), therapists can use such material to expand their awareness of the range of possible influencing factors and meanings which might motivate their actions.

As identified under Criterion 5, the majority of questions in the final collection are more specifically-focused on a particular issue or goal and, thus, may be considered solution-focused or, perhaps alternatively, as problem-solving (e.g. Feo, 2012) or as instances of behavioural activation or problem-management in CBT (Ekberg & LeCouteur, 2014a; Blackburn, & Davidson, 1990). The

relative infrequency, in the current sample, of more general, process-focused questions regarding the overall helpfulness of therapeutic approaches raises some important practical issues for pluralistic therapy. The more general, process-focused questions open up a space for the client to give ideas generally regarding the overall therapeutic approach and how they experience the therapy sessions. In contrast, the more specific questions foreground problems, solutions and goals beyond the therapy room and, as such, concurrently de-emphasize the therapeutic experience and process. Thus, the more specific questions about what might be helpful necessarily de-emphasize some aspects of meta-therapeutic dialogue. These include the foregrounding the client's expertise and own ideas regarding what approaches and activities are therapeutically helpful *within* therapy sessions and how they are currently experiencing the approaches in the sessions.

It may be that therapists pose these more general, process-focused questions more during formal opportunities for eliciting clients' ideas, using personalization tools like the *Therapy Personalization Form*. The current study does not focus on such opportunities. Nonetheless, there may be value in also topicalizing these more general, process-focused issues as they arise non-formally. For example, even if a client has agreed to a particular therapeutic approach more generally, there may be indications that they feel that it is not as helpful at this particular moment. Process-focused talk is also empirically supported as a helpful therapeutic activity (Cooper & McLeod, 2011; Hill & Knox, 2009; Shafran et al., 2016) More general, process-focused questions about the overall helpfulness of a therapeutic approach or strategy at a particular moment and how the client is currently experiencing it may be one route towards responsively and collaboratively adjusting the approach at such points. This ensures that therapist is not assuming a monolithic, permanent fit of a particular therapeutic approach for the client solely on the basis of an initial agreement to use it. Such an assumption would contradict the basic principle of pluralistic therapy that different things are helpful for different clients at different points in time. Further research is of course required to investigate as to whether an increased number of more process-focused questions about what might be helpful would contribute to an improved therapeutic alliance and overall therapeutic outcomes.

5.7.3 Limitations & future research

A major limitation of the current study concerns the sampling process. To begin with, 42 is a relatively small number of sessions to sample for the occurrence of meta-therapeutic talk regarding methods. Added to this, the infrequent occurrence of questions about what might be helpful means that findings from the current collection must be interpreted in the context of a limited number of cases. This means that the current findings regarding questions about what might be helpful may need to be discarded or adjusted in the light of new contradictory findings based on a larger sample. In addition, 6 of the 42 sampled sessions had to be taken from later in the therapy, since some of the first four sessions were not available for some clients. This might affect the amount of questions about what might be therapeutically helpful, since meta-therapeutic dialogue is presumed to be most frequent in the earlier sessions (McLeod & Cooper, 2012).

A final sampling limitation concerns how 12 out of the 28 cases of questions in the current sample are derived from one therapist's practice across three different clients. As such, the findings regarding questions about what might be helpful (i.e. described in Chapters Five through Eight) may be skewed towards representing this therapist's practice. However, there are several mitigating factors which contribute transparent and worthwhile findings and thus partially compensate for this possible skewing. First, Table 3.2 in Chapter Three ensures transparency in terms of which extracts have been sourced from which therapist-client pair. Second, the therapist sampled across three different clients is one of the two qualified therapists, so it is informative in itself to have amply sampled the practice of a pluralistic therapist with over 20 years' experience. Third, some valuable practice-focused findings relating to meta-therapeutic dialogue can be drawn from comparing one therapist's practice across different clients (cf. Chapter Eight).

Another limitation of the current selection criteria is a possible arbitrariness since some excluded cases may also involve meta-therapeutic dialogue about what might be helpful. For example, asking clients about what has been helpful in the past, and asking clients for their views on an idea put forward by the therapist, can all be considered forms of meta-therapeutic talk and can

all be conducted in more and less dialogical ways. In particular, talk about what has been helpful in the past can provide relevant examples to inform more future-oriented talk regarding what might be therapeutically helpful (Cooper & McLeod, 2011). Foundational to the current decision to not include these other cases of meta-therapeutic talk is the impetus to initially focus on therapists' most explicit efforts to invite clients' own ideas about what might be therapeutically helpful. This decision was taken in the context of the lack of research in this area. Furthermore, the distinctions made in the current selection process have now highlighted several means by which meta-therapeutic talk is conducted, the study of which would further knowledge of how clients and therapists can engage more and less dialogically in talk about what might be therapeutically helpful. It would be particularly useful in guiding future practice recommendations to investigate the relationship between these other forms of meta-therapeutic talk and therapeutic outcomes.

A further limitation of the current study relates to the possible overly narrow definition of dialogue assumed by selection criteria. That is, the assumption is that the therapist's production of suggestions regarding what might be therapeutically helpful, in effect, de-emphasizes the client's own ideas. However, the notion of the client *independently producing content* becomes less relevant in scenarios in which both the client and the therapist may have contributed content in the lead-up to the therapist actually producing the suggestion. The issue here concerns whether dialogue is conceptualized as momentary occurrences or as a process which develops over extended periods, whereby the client and therapist implicitly co-construct new meanings together.

The current study is thereby limited in scope in terms of focusing more on the immediate context of explicit meta-therapeutic talk regarding what might be helpful and less on the extended prior content. The focus on more explicit instances could therefore be considered convenient, low-lying fruit in terms of having a straightforward relevance for investigating how such talk is executed in practice. In contrast, the issue of how therapists and clients implicitly work up to explicit dialogical opportunities requires a more complex analytic harvesting. A relevant example to follow in this respect are Shaw et al. (2016) and Pino et al. (2016) who examined, how counsellors, and doctors, respectively made it relevant for cancer patients to engage in delicate end-of-life talk. Both of these

studies identified how the professionals prioritized interventions, such as *open elaboration solicitations* (Pino et al., 2016), which made it somewhat relevant – but not an interactional requirement – for patients to engage in end-of-life talk. This provision of some relevance by the professional, without constraining the client, is another potential implicit means by which therapists might provide informal opportunities for clients to contribute ideas on what might be helpful.

5.7.4 Contribution to existing CA literature

Criterion 5 highlighted how therapists can sometimes pursue clients to produce content to fill solution slots which the therapist has structured. We noted how, depending on the amount of pursuit and alignment or uptake by the client, this practice can become less dialogical and tend towards being interactionally coercive. These findings build on previous CA studies regarding telephone counselling. For example, some related practices such as script proposals, used by counsellors to pursue the client's alignment with advice, were highlighted by Emmison, Butler and Danby (2011). In addition, Potter and Hepburn (2011a; 2011b) investigated a further questioning practice, *tag questions*, which they identified as potentially having interactionally coercive effects since these questions work to make it relevant for callers to accept that a course of action is desirable, when actually the caller has already resisted doing so. The findings regarding solution slots and pursuit in the current chapter expand on these studies by illustrating how related practices can be found in face-to-face therapeutic contexts. Furthermore, the current findings are the first to highlight therapists' creation of solution slots as practice for securing client alignment with a particular therapeutic agenda.

Chapter Six: Contexts in which therapists pose questions about what might be therapeutically helpful

6.1 Chapter overview

In this chapter, I will present a comparative analysis of two different contexts in which therapists use questions about what might be helpful to create opportunities for meta-therapeutic dialogue. Part One focuses on the first of these contexts, which consists of instances in which therapists pose questions directly after clients have referred to a hoped-for state of affairs. As anticipated in Chapter Four, Part One of the current chapter shows the therapist moving from exploring the experiential and situational content of the client's troubles-telling towards a meta-therapeutic focus on this. Part Two then examines instances in which therapists frame the question as a shift to an entirely new topic. In order to present a nuanced account of the concrete situations in which therapists pose these questions, variations of cases within these two contexts will also be highlighted.

The cases in this chapter do not comprise an exhaustive illustration of the contexts in which therapists pose these questions. However, an examination of the particular contexts in Parts One and Two gives rise to some substantial clinical implications in terms of the practical and relational considerations facing therapists regarding whether or not to pose such a question in the first place.

6.2 Part One: After the client refers to a hoped-for state of affairs

In Part One, we will examine cases where the therapist poses a question about what might be helpful as a relevant next action after the client has made a reference to a hoped-for state of affairs. Particularly in Illustrations 2 (Section 6.2.2) and 3 (Section 6.2.3), this raises some observable complexities in terms of the therapist prioritizing posing this question over attending to other possible therapeutic relevancies, including those spearheaded by the client.

6.2.1 Part One, Illustration 1: "I want it to be the other way around"

Extract HCYDT occurs 34 minutes into the second post-assessment session. The extract begins as they discuss the client's process in the current session. The therapist poses a question about what might be therapeutically helpful in line 36. We will now focus on the interactions leading up to this.

Extract HCYDT *Session#2/Start34minutes/PairD*

```
 1  C:   ((continuing)) it's like that feeling comes first and then
 2       [I've  ] got to examine (.) what that ↑feeling=
 3  T:   [↑ye:ah]
 4  T:    =↑ye:ah
 5       (.)
 6  C:   ↑I:s (1.2) and the:n once I- (0.8) am >into the process >>and
 7       we're=ex↑amining< it hh. then I start a↑greeing with it=
 8  T:   =You d:o
 9  C:   ↑Ye:ah .hhh=
10  T:   =Hm pt=(>I[s that so<)]
11  C:             [↓Yeah  ↓we:]ll you've got a point there m:m
12  T:   °(Would) have bee[n easier]°
13  C:                    [Ye:ah   ] well it was quite a horrible thing
14       to d:o.
15  T:   Ye:ah
16  C:   °Ye:ah° .HHh
17  T:              >But then  [when we]  look- I- I- .h< but then
18  C:                         [H H H H]
19  T:   when we've looked at it (0.3) and we really >like in this
20       session< [>like we've been tak]ing apa:t<, .hh the reality
21  C:            [M:hm                ]
22  T:   is, it's not is i[t?]
23  C:                    [N:]o .hh and that's whe:re I think is- that
24       my f:↑irst go- that's whe:re (.) the kind of (0.8) leading
25       by .h e↑motio[ns   ] that <a:re ↑often irrational> uh-
26  T:                [YE:AH]
27  C:   E#- e::hm (1.6) °and >how I make my
28       thoughts fit in°=
29  T:   =Fit >in those emotions<
30  C:   With those e↑motions.
31       >[I want it to] be the ↑#other #way #ar↑ound<
32  T:    [Ye:ah       ]
33  C:   SHHih. HHHEHH[h ]
34  T:                [Ye]:ah
```

35 C: hh. .shhih
36 T: h. >And I guess< and ↑how- ↑how can you do that?

In line 11, the client changes footing from assessing their own process (lines 1-2, 6-7), to illustrating an inner critical voice they experience. Adopting the same critical voicing, the therapist affiliatively offers an extension of the client's turn in line 12. In lines 17-22, the therapist then shifts out of the voicing activity to produce an assessment contrasting with the assessments the client and therapist have just previously constructed with the critical voicing: "But then when we've looked at it, the reality is it's not is it?". In line 23, the client aligns with the therapist's assessment by producing an extended agreement. This possibly includes a cut-off reference to the client's first therapeutic goal ("my first go-"). The client then goes on to reference an aspect of their process which they have been discussing previously in the current session ("the kind of leading by emotions"). In line 29, the therapist collaboratively completes this description, which the client aligns with by integrating it into their turn in line 30. The client then refers to a hoped-for state of affairs, "I want it to be the other way around". The client's non-uptake of further opportunities to talk in lines 33 and 35 show that they are now treating their turn as having ended. In line 36, the therapist then builds on the client's turn-final reference to a hoped-for state of affairs to pose a question about what might be therapeutically helpful ("and I guess and how- how can you do that?").

The client's reference to the hoped-for state of affairs in line 31 comes at the end of their extended agreement (lines 23-25, 27-28, 30) with the therapist's contrastive assessment of the critical voice. The therapist's contrastive assessment has set up the normative desirability of not agreeing with the critical voice: "but then when we've looked at it, the reality is it's not is it?" Thus, the client makes their reference to a hoped-for state of affairs (">I want it to be the ↑#other #way #ar↑ound<") after the general thrust of this reference has been articulated by therapist. So having previously evoked the footing and arguments employed by the critical voice (lines 6-7, 11-12, 13-14), the client has now articulated a therapeutically-relevant, therapist-endorsed goal of not agreeing with this critical voice.

The client's reference to the hoped-for state of affairs at the end of their turn has a troubles-telling quality due to its depiction of an experience with a severe or exceptional nature (Ruusuvouri, 2007). That is, although the client wants "it to be the ↑#other #way #ar↑ound", the implication is that reaching this state of affairs is difficult – if not impossible – for the client to do at this point. Furthermore, the client's use of a closure-implicative idiomatic phrase, "the ↑#other #way #ar↑ound", is a common feature in the construction of complaints (e.g. Drew & Holt, 1988), which adds to the response-mobilizing quality of this reference to a hoped-for state of affairs. Finally, the paralinguistic features of the client's reference here also intensify the implicit affective tone of the client's goal-statement (Ruusuvouri, 2007; Heritage, 2011): ">[I want it to] be the ↑#other #way #ar↑ound<". These features include the client's fast-paced production of this piece of talk and the dramatic manner in which the volume becomes lower but the pitch becomes higher when producing the turn-final idiomatic phrase "other way around". The troubles-telling and closure-implicative qualities and the intensifying paralinguistic elements all make relevant an affiliative response from the therapist, which would validate the client's difficulties or otherwise display solidarity or endorsement at this juncture (Couper-Kuhlen, 2012; Feo & LeCouteur, 2017; Heritage, 2011; Jefferson, 2015; Ruusuvouri, 2007; Stivers, 2008). However, as well as making an affiliative response relevant from the therapist, the client's turn-final reference to a hoped-for state of affairs also potentially creates the opportunity for a different kind of response from the therapist. In highlighting their needs and desires at the end of their turn, the client also creates an opportunity for some kind of helpful (e.g. problem-solving) response from the therapist (Butler et al., 2010). Thus, the client's turn is also potentially an implicit request for assistance to the therapist (Pino, 2016). The relevance of this opportunity for the therapist to respond in a helpful manner may be further heightened since the therapist themselves has very recently implicitly endorsed the therapeutic strategy of not agreeing with the critical voice. As such, the therapist may be treated as somewhat responsible to assist further now that the client has referred to a hoped-for state of affairs that fits with the therapist-endorsed strategy.

The client's turn-final reference to a hoped-for state of affairs is therefore an equivocal move. This equivocality lies in the different possible relevancies it creates for the therapist's response. On the one hand, the client's turn makes relevant an affiliative, empathic endorsing response by the therapist, whereas on the other, it creates an opportunity for a helpful, problem-solving response. The equivocality of this turn affords some flexibility to the therapist in terms of which of these relevancies are prioritized and foregrounded in their response. In line 36, by posing a question about what might be helpful to the client, the therapist de-prioritizes the relevance of affiliating with the client's prior turn and foregrounds the relevance of responding helpfully.

The therapist's repair in line 36 from "h. >And I guess<" to "and ↑how- ↑how can you do that?" also shows them orienting to some complication in responding. This repair provides some evidence that the therapist was initially going to display a perspective, prefaced by the epistemic marker "I guess". As such, this repair illustrates how another potentially helpful response available to the therapist would have been for them to display a perspective or share their ideas regarding what might be therapeutically helpful. In abandoning this possible bid to more substantially take the floor and instead posing a question, the therapist can be seen to prioritize the creation of an opportunity for the client to first display a perspective on what might be therapeutically helpful.

As we have seen, the therapist's question represents a shift towards foregrounding the relevance of a helpful or problem-solving – as opposed to just affiliative – response to the client's equivocal reference to a hoped-for state of affairs. The therapist can be seen to presume a common ground with the client in posing this question at this point (Strong, Pyle & Sutherland, 2009). One feature contributing the relevance of a helpful response is the therapist's use of the determiner "that", which equates the grammatical object of the question with the hoped-for state of affairs. Prefacing the question turn with "and" also enables the therapist to construct the upcoming action as working to articulate an inferable-but-missing element in the client's just-prior talk (Bolden, 2010). The "and"-preface also indicates that the upcoming action by the therapist forms part of a professional agenda (Heritage & Sorjonen, 1994). We can see from the therapist's question that the agenda in this case is one of creating opportunities for meta-therapeutic dialogue regarding what

might be helpful. So, using the determiner "that" and an "and"-preface, the therapist constructs their question turn as working to elicit an agenda-relevant implication of the client's just-prior talk, namely how the client can start to work towards the hoped-for state of affairs. This can be considered a somewhat *helpful response* by the therapist since it explicitly focuses the talk on what might help the client achieve this hoped-for state of affairs – or therapeutic goal – which they have just referenced.

In summary, there is a complex underbelly to the just-prior context of the therapist's question about what might be helpful. In foregrounding the relevance of a helpful response, it prioritizes an opportunity for meta-therapeutic dialogue but concomitantly de-emphasizes the possibility of a more affiliative, empathic response to the client's experiences at this point. As noted by numerous CA researchers, this is a common dilemma for professionals who have to navigate between the affective, local interactional relevance of displaying compassion and empathy for clients and the institutional impetus to progress a task-focused, often problem-solving, agenda (e.g. Feo, 2012; Hassan, McCabe & Priebe, 2007; Jefferson & Lee, 1992; Muntigl & Horvath, 2014; Ruusuvouri, 2007; Weiste, 2016; Ekberg et al., 2016; Stokoe & Sikveland, 2016; Voutilainen, Peräkylä & Ruusuvuori, 2010a).

A further complicating factor concerns how this helpful response takes the form of a question which then makes it relevant for the client to give ideas or suggestions. That the therapist's helpful response takes the form of a question is a feature which participants might subsequently treat as a *somewhat* helpful response. This issue of the therapist's question about what might be helpful emerging as a *somewhat* helpful response will be explored in more detail in the clinically-focused discussion section (6.2.4) of this chapter.

We will now examine two further cases in which the therapist poses a question about what might be helpful shortly after the client has referred to a hoped-for state of affairs. In these further cases, the prioritization work done by the therapist in posing the question stands in bolder resolution than in Extract HCYDT. This is due to having to first recover the relevance of a particular meta-therapeutic agenda in the face of the client's most recent talk.

6.2.2 Part One, Illustration 2: "I wanna be kind of happy but"

We join Extract WITBR as the therapist asks the client a question about an inner critical voice which they experience (lines 3-4). The therapist poses a question about what might be therapeutically helpful in lines 23-24 and 26. We will now focus on the interactions leading up to this.

Extract WITBR *Session#3/Start35minutes/PairC*

```
 1        (1.0)
 2   T:   .HH But THAT voice is saying you're nothing because:, (.)
 3        you've had no °exp↑eriences?=is that what it's saying?°
 4        (.)
 5   C:   In a way, but- I'm nothing because: I °am nothing,°
 6        (0.6)
 7   C:   I probably haven't had (.) enough exp#eriences or whatever.
 8        (0.8)
 9   ?:   .hh
10   T:   Yea:h.
11   C:   To, (0.7) (cloud) over or cover it.
12        (0.9)
13   C:   °(An')° (.) °>what I see as, (1.0) a bit of (pool shark),
14        (0.5) something just to keep my life, (0.7) living.
15        (0.9)
16   C:   Someone to (treat) you=↑ah that l↑ooks good >↑oh somebody
17        likes me=or loves me? [°(you know the way< or)] whatever,°
18   T:                         [Yea:h.                ]
19        (2.4)
20   C:   But, (.) I suppose, (1.4) ((movement during pause)) ↓maybe, (3.0)
21        °I wanna be kind of happy=but.°
22        (0.9)
23   T:   What's the best ar:g- I mean when that voice says (.) you're
24        ↓nothing, (0.5)
25   C:   °Uhuh.°
26   T:   .hh wha- what is the best response to that.
27        (1.7)
28   C:   °I don't have a response to it=that's the thi[ng° I just]
29   T:                                               [Nyea:::h  ]
30   C:   agree with it.
```

In line 5, the client responds to the therapist's question about the critical voice with an initial partial agreement ('in a way'), and then uses 'but' to contrastively extend their turn (lines 7-21). The

therapist withholds from taking a conversational turn in lines 8, 9, 12, 15 and 19, which facilitates the client to continue extending their turn. In lines 13-14, the client shifts from a report about the critical voice to a report about what kind of things they would generally like to have in their life. They bring this turn to point of prosodic completion by producing 'but' with falling intonation in line 21. In lines 23-26, the therapist launches a question regarding what the 'best' response to the voice might be. This question invites the client to share ideas regarding what might be helpful in responding to the voice.

In lines 20-21, the client makes a reference to a hoped-for state of affairs: "But, (.) I suppose, (1.4) ((movement during pause)) ↓maybe, (3.0) °I wanna be kind of happy=but.°". This reference is epistemically-downgraded through the epistemic markers "I suppose", "↓maybe" and "kind of". There are also some paralinguistic features, which further add to the hesitant and somewhat equivocal production of this reference to a hoped-for state of affairs. For example, the pause after the continuing intonation of "↓maybe," produces a trailing-off effect, which also works to mitigate the certainty of what the client is going to say next. In addition, the prosodically-complete but syntactically-incomplete "but" in turn-final position also contributes to an epistemically-downgraded position by constructing the implication that this hoped-for state of affairs is somehow problematic. The client's hesitant and epistemically-downgraded production of this reference to a hoped-for state of affairs renders this an equivocal turn. Although they are referring to a hoped-for state of affairs, the hesitant and downgraded features of this conversational turn nonetheless construct some problem regarding the hoped-for state of affairs referred to. On the one hand, the client is saying that they would like to attain this, but on the other hand, they are also indicating that this is somehow problematic.

Similarly to Extract HYCDT, the equivocal nature of the client's reference to a hoped-for state of affairs opens up several possible relevancies for the therapist's response. For example, unlike Extract HCYDT, moving to affiliate is not so obviously relevant here, but it might still be therapeutically relevant to attend to or explore the difficulty being constructed by the client. Another possibility is that the epistemically-downgraded packaging of something that the client

wants or needs may work as an implicit request for the therapist to respond in a helpful manner (Pino, 2016). However, yet another conflicting possibility is that the client's epistemically-downgraded packaging actually decreases the relevance of the therapist responding helpfully, since the client has already displayed that there is something problematic about this hoped-for state of affairs.

As it transpires, in the case of Extract WITBR, in response to the client's reference to a hoped-for state of affairs, the therapist poses a question regarding what might be helpful: "when that voice says (.) you're ↓nothing, (0.5) / .hh wha- what is the best response to that." (lines 23-24/26). This shows them prioritizing creating an opportunity for meta-therapeutic dialogue and consequently de-prioritizing other potentially relevant therapeutic material in the client's turn. Thus in both Extracts WITBR and Extract HCYDT, after the client equivocally refers to a hoped-for state of affairs at the end of their turn, the therapists build on this reference as a common and reasonable ground for posing a question about what might be helpful.

A further complication associated with the therapist's posing of the question in Extract WITBR is that it initiates a topic shift away from the client's most recent reference to a hoped-for state of affairs in line 21 ("°I wanna be kind of happy=but.°"), back to focus on the critical voice which they had been discussing about a minute or so previously (lines 1-5). However, the client then moved stepwise to a consideration of other goals and issues in their response (lines 5-21). As we have seen, the therapist then makes fortuitous use of the client's most recent reference to a hoped-for state of affairs to shift back, possibly implying that considering the "best response" to the voice could be a route towards the most recent reference to the hoped-for state of affairs, that is, being happy.

The topic shift by the therapist in Extract WITBR constitutes a clear illustration of Clayman and Heritage's (2002) and Sacks' (1995) observations that questions can be used to direct topic and action agendas. Given this topic shift, we can draw a distinction between Extract WITBR as compared to Extract HCYDT, since Extract WITBR more demonstrably executes a topic shift towards the therapist's agenda, which is, in this instance, to re-focus the talk on the critical voice and

introduce the agenda of considering what might be helpful in managing this voice. In contrast, in Extract HCYDT, the focus of the question about what might be helpful is more immediately relevant to the reference to the hoped-for state of affairs the client has just made. Extract WITBR is therefore a more pronounced illustration of how therapists can use questions about what might be helpful to re-topicalize and foreground their meta-therapeutic agenda in the face of the client moving stepwise to focus on other topics.

6.2.3 Part One, Illustration 3: "I want to deal with this bit that's coming…"

Extract BW is taken from 22 minutes into the second post-assessment session. The therapist poses a question about what might be helpful in lines 25-26.

Extract BW *Session#2/Start22minutes/PairD*

```
 1  T:   >O↓kay °get=you°
 2       (0.4)
 3  C:   °Ye:ah°
 4       (1.7)
 5  C:   .hh but ↓ye:ah I- HHH (1.1) my main concern at-(.) the mo:ment
 6       (0.3) i:s (1.4) to worry l#ess #about this let[ter and hi]s
 7  T:                                                  [MM:m      ]
 8  C:   reaction, .hh what's coming=↑where do we go ↑next, .hh e:hm
 9       °°I've ghot a ↑buhsiness to set up°° H .H ↑e:hm £I've got just
10       (1.5) h loads of things to do, [and to] focus my energy on .hh
11  T:                                  [Ye:ah ]
12  C:   >and I =wa:nt< to (0.3) de:al w#ith h (0.3) ↑THIS bit that's
13       coming .hh in the: most construct[ive  l]least energy expe(h)n-
14  T:                                    [°ye:ah°]
15  C:   least emotional en(h)er#gy ex(h)p#ending way .hh °°cause I
16       just°° feel so exhau:[sted      ]
17  T:                        [↓Yeah I  b]et
18       (0.4)
19  C:   [I          ↓re::::ally          ] [↓(no:w)    ]
20  T:   [°We°'ve both been >talking about] [it and think]ing about it<
21       all the t[ime, and=it's] >going round and round in your ↓head<
22  C:            [Yeah=h       ]
23       (0.3)
24  C:   °Ye:ah°
```

25 T: .Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the-
26 best (0.3) way °of dealing with=it.°
27 ?: .hh °.shih°
28 (6.0)

We join as the client starts a new turn in line 5 by topicalizing, and then, elaborating what their "main concern at the moment is". In lines 12-16, the client outlines a goal ("I want to deal with this bit that's coming in the most constructive, least… emotional energy expending way") before ending their turn with an account "cause I just feel so exhausted". In line 17, the therapist acknowledges the client's turn and then there is a slight (0.4) pause in line 18 after which the client and therapist overlap. In their bid to take a turn, the client starts to further elaborate ('I really now'), before ceding the conversational floor to the therapist. This enables the therapist to complete a formulation regarding the client's just-prior talk (lines 20-21). After the client minimally acknowledges this formulation, the therapist produces a question about what might be therapeutically helpful in lines 25-26.

In lines 12-15, the client outlines a goal or a state of affairs they desire: "I wa:nt< to (0.3) de:al w#ith h (0.3) ↑THIS bit that's coming .hh in the: ...least emotional en(h)er#gy ex(h)p#ending way". As with Extracts WITBR and HCYDT, this reference to something the client needs or wants would potentially work as an implicit request to the therapist for assistance, such as suggestions or a problem-solving response.

Also similarly to Extract HCYDT, this reference to a goal partakes of troubles-telling features, including the construction of an extreme scenario through the use of the extreme case formulations (e.g. in line 13: "most"/ "least energy expending way") and the intensifiers "just" and "so" alongside the non-gradable, extreme adjective "exhau:sted" (line 16). Furthermore, the client uses some paralinguistic features to emphasize their telling, including switching back and forth from a whispering intonation (lines 9, 15-16) to prosodically underlining key adjectives (e.g. line 10: "loads"). This paralinguistic emphasis heightens the affective tone of the client's turn (Ruusuvuori, 2007). Relatedly, the laughter interpolated through the phrase "en(h)er#gy ex(h)p#ending" (line 15)

serves as a marker of trouble in the production of the client's turn (Potter & Hepburn, 2010), which further heightens the turn's affective tone.

As such, so far with Extract BW, it would look like we are on track for the client to produce an equivocal reference to a hoped-for state of affairs which then opens up some opposing relevancies for the therapist's response. However, there is an important difference between Extract BW and Extracts WITBR and HCYDT since, in Extract BW, the client immediately follows up this reference to a goal with an account or explanation: "°°cause I just°° feel so exhau:sted" (lines 15-16). This means that their reference to a goal or hoped-for state of affairs is not positioned at the end of the client's turn. It therefore becomes more relevant for the therapist to respond this turn-final material first before they can address any other relevancies in the client's turn (Sacks, 1987). Furthermore, since this turn-final material takes the form of troubles-telling about a difficulty (i.e. exhaustion), it is relevant for the therapist to affiliate or emotionally validate this in some way (Feo & LeCouteur, 2017; Heritage, 2011; Jefferson, 2015; Ruusuvuori, 2007).

As it transpires, the therapist here initially minimally acknowledges the client's turn-final explanation that they are exhausted by producing a non-extended agreement of "Yeah I bet" and then leaves a 0.4 second pause in lines 17-18. That the therapist's agreement here is prosodically downgraded shows that they are not yet moving to fully endorse or affiliate with the client's stance (Couper-Kuhlen, 2012). Furthermore, the use of "I bet" as an acknowledgement is often closure-implicative (Schegloff, 1984). The therapist here seems to be refraining from fully affiliating with the client and may be moving towards closing-down the client's troubles-telling. However, in overlapping with the therapist in line 19, the client treats the therapist's "I bet" as a continuer. The client's apparent bid to further develop the troubles-telling may also be working to pursue a more substantially affiliative response from the therapist (Feo & LeCouteur, 2017; Jefferson, 2015; Ruusuvuori, 2000). However, the therapist overlaps with the client's bid to take the floor and somewhat more substantially affiliates with the client's prior troubles-telling by producing a summary of what the client and therapist have been doing in the session (lines 20-21: "(°We°'ve) both been >talking about it and thinking about it< all the time"), and then, of the client's experience

(line 21: “and=it's >going round and round in your ↓head<”). Nonetheless, the therapist’s overlapping turn does more than simply affiliate here, since working to summarize what the client has been talking about moves to close the topic (Jahoda & Antaki, 2010). Furthermore, the idiomatic and formulaic expression “going round and round in your head” works to summarize the client’s prior talk without adding any new or arguable details, thereby enabling the therapist to close-down the client’s trouble-telling and clear the floor for a new activity (Holt & Drew, 2005; Antaki, 2007). The therapist’s summary here also plausibly contains an implicit pre-account for the therapist’s upcoming question about what might be helpful (Parry, 2009; Antaki 1994). This is due to the emphasis on how the client’s prior deliberations to this point have been repetitive (‘going round and round’) and therefore works to provide a pre-account for the benefits of engaging with the upcoming question.

In lines 23-24, the therapist waits for the client to confirm this summary before going on to launch the question about what might be helpful in line 25. The therapist is thus treating the client’s alignment with this summary as necessary before moving on to pose the question about what might be helpful. This further illustrates the importance of the therapist’s summary in moving from a troubles-telling sequence towards the meta-therapeutic agenda of talking about what might be helpful for the client.

So what we are seeing here is that after the client has finished their turn with a troubles-telling element and after they show signs of moving to pursue affiliation from the therapist, the therapist then has to manage this relevance to affiliate before then working to recover the opportunity to ask a question about what might be helpful. The question can then be seen to link back to the client’s prior reference to a hoped-for state of affairs. In the case of Extract BW, the therapist achieves this by engaging in some affiliative work which is simultaneously closure-implicative. This therefore works to clear the floor to pose a question about what might be therapeutically helpful. As such, Extract BW constitutes an instance in which the therapist has to respond to other relevancies before reviving an opportunity to pose a question about what might be helpful.

6.2.4 Clinically-focused discussion

In Part One of the current chapter, we have examined three cases of therapists posing a question about what might be helpful shortly after the client has equivocally referred to a hoped-for state of affairs towards the end of their conversational turn. In all of these cases we noted that the therapist prioritizes a problem-solving framework of talking about what might be helpful concerning a particular issue. We noted that in Extracts WITBR and BW, this prioritization work was further highlighted by the therapist's movements towards a particular meta-therapeutic agenda in the face of the client's talk about other issues. In posing these questions about what might be therapeutically helpful, the therapist is ostensibly working towards fulfilling the pluralistic therapy mandate to create opportunities for meta-therapeutic dialogue. In Sections 6.2.4.1-6.2.4.5, I will now discuss several clinical issues arising from this analysis.

6.2.4.1 Clients' equivocal packaging of hoped-for states of affairs The current findings show the re-occurrence of what I have been terming clients' equivocal references to hoped-for states of affairs. Viewed from the paradigm of pluralistic therapy, these references could be equated with therapeutic goals or other envisioned scenarios which would represent a therapeutic move forward for the client (Cooper & McLeod, 2011). These references can be considered *equivocal* on the basis that they may solely be performing troubles-telling or they may also work as an implicit request for assistance (Pino, 2016) or that they may be performing both of these functions at once (Levinson, 2013). The equivocality of these references stems from how they contain goal-relevant statements, while still also being packaged as troubles-telling. The troubles-telling packaging detracts from the forward-looking effect of the goal-relevant material. That clients can treat goal-relevant material in an equivocal manner is a clinically significant issue since it demonstrates how actually articulating and committing to therapeutic goals may be a complex process, in which clients' ambivalences and doubts can be displayed. For example, although the client is articulating a goal, if they are doing so

in a troubles-telling style, this can simultaneously construct the goal as something which they are not sure they are able to achieve.

This finding of equivocal packaging problematizes the goal-oriented discussions that the client and therapist might have regarding what might be therapeutically helpful and raise the question for therapists as to how they might optimally support clients during this process. For example, Cooper and McLeod (2011) acknowledge that not all clients may feel that they are able, or that it is helpful, to articulate and decide goals, but they still assume *most* clients will. Is this assumption a helpful one if clients also display ambivalence? How open to alternative possibilities should pluralistic therapists be concerning the helpfulness of therapeutic goals? Should therapists be more sensitive to ambivalences displayed through troubles-telling features even when clients have apparently produced goal-relevant material? If so, how can therapists work with such ambivalent displays according to the person-centred and goal-oriented principles of pluralistic therapy? These questions raised regarding how to practice in a humanistic, yet goal-oriented manner also point to the complexity of the task facing therapists when responding to clients' equivocal references. Further evidence for this complexity stems from Voutilainen et al.'s (2014) finding that when a storyteller tells an emotionally ambivalent story, the recipient shows increased autonomic nervous system activity. Voutilainen et al. concluded this increased activity might be due to the complexity of the task facing the recipient in appropriately responding and affiliating with the ambivalent story. These findings from the correlation of interactional analysis with physiological measurements bolster the argument for further support and training for pluralistic therapists in responding to client's equivocal packaging of goal-relevant material.

6.2.4.2 Relational challenges in prioritizing problem-solving/meta-therapeutic agenda A further clinically relevant issue concerns how the therapist's creation of an opportunity to pose a question about what might be helpful involves a concomitant de-prioritization of responding to other aspects of the client's talk. In the cases we have examined, the therapist's questions about what might be helpful can be seen as a bridge from empathically exploring a problem to talking about how it might

be resolved or alleviated. We have noted how, in responding to equivocal turns from clients, pluralistic therapists face a common professional dilemma regarding when and how to navigate between the affective, local interactional relevancies of affiliating and displaying empathy and the institutional impetus to progress task-focused, problem-solving agendas (e.g. Feo, 2012; Ruusuvouri, 2007; Stokoe & Sikveland, 2016). Pluralistic therapists must therefore judge which of these competing therapeutic relevancies it is important to prioritize at any particular point. Furthermore, as noted by Strong, Pyle and Sutherland (2009), a "shift from talking about problems to talking about solutions....[is] a significantly different conversational focus the client might not want to take up" (p.179). Indeed, Feo (2012), among others, documents the misalignments which can occur when professionals attempt to shift from an empathic to a problem-solving framework. Clearly, any such shift "is a relationship management challenge as well as a rhetorical one" (Strong, Pyle & Sutherland, 2009, p.180).

This challenge of how to relationally manage the shift from an empathic to a problem-solving/meta-therapeutic framework highlights the further issue of the response possibilities available to therapists in the face of equivocal references by clients to hoped-for states of affairs. As we have seen, in the three data extracts discussed in Section 6.2, it is potentially open to the therapist to prioritize the empathic or the problem-solving relevancies and, indeed, as illustrated in Chapter Four, both are official components of the pluralistic therapist's job description. Thus, when the client makes this equivocal reference, they are doing so in a response space in which it is also ambiguously or potentially open as to how the therapist will respond, namely, whether they will prioritize the empathic or the problem-solving relevancy. It seems reasonable to suggest that these ambiguities – both in the client's reference and in the possibilities for the therapist's response – could be explicitly highlighted and explored in pluralistic training. This would enable therapists to recognize instances of clients' equivocal references to hoped-for states of affairs and to then be in a position to respond in a highly-considered manner. Issues raised during such a training module might include the relational consequences of switching from the more affectively-oriented, local considerations to attempting to progress institutional tasks such as goal-focused or task-focused

questions, which can form part of meta-therapeutic dialogue. What are the different ways in which clients might experience such a shift? When and how should therapists manage this shift? Is it possible to manage this shift in a manner that attends to both empathic and problem-solving relevancies? Meta-therapeutic dialogue is theorized to strengthen the therapeutic relationship, but the current findings show that substantial relational work may be at times required to secure the client's alignment in even just to initially shift to a meta-therapeutic framework.

6.2.4.3 Conflicting constructions of the client in pluralistic therapy The shift between empathic and problem-solving/meta-therapeutic frameworks also has implications for how the therapist is constructing and treating the client. As observed by Jefferson and Lee (1992), the prioritizing of one or the other relevancy has significant implications for how the troubles-teller (in this case, the client) is constructed in the interaction. If the professional affiliates and displays compassion, then the client is treated mutually, as an equally able member of the community. However, if the professional shifts to a problem-solving agenda, then the client is constructed as member who requires help and who is possibly less knowledgeable or less expert than the member who is shifting to assist them with a problem-solving agenda (Clayman & Heritage, 2014). A defining feature of meta-therapeutic dialogue is that it takes place on a mutual, adult-to-adult footing (McLeod & Cooper, 2012). However, as soon as the therapist prioritizes a problem-solving approach, this implicates the therapist as the expert guiding the interaction and the client as the inexpert or less knowing participant from whom ideas must be elicited. Thus we come upon a practical paradox arising when the therapist works to create opportunities for meta-therapeutic dialogue. On the one hand, meta-therapeutic dialogue is conceptualized as a mutual process involving two participants who can both be treated as able to make equally-valued contributions. And yet, on the other hand, when the therapist moves to create an opportunity for meta-therapeutic dialogue focused on what might be helpful for the client's difficulties, the implication is that the client is a less able participant requiring assistance. The paradox arises in the possibility that meta-therapeutic dialogue may not be

conducted on such an equal footing if it is the therapist who is forwarding this agenda and if the client is not fully aligned or on board regarding the need for, and timing of, such an agenda.

6.2.4.4 Questions about what might be helpful as dialogical but challenging moves To summarize our discussion of clinical implications thus far: Clients recurrently engage in a clinically-significant practice of making equivocal references to hoped-for state of affairs. The therapist's potential response to the client's equivocal reference is also projectably open or ambiguous in terms of whether they will prioritize the empathic or the problem-solving/meta-therapeutic relevancies. Therapists may thus benefit from training in the clinical and relational considerations arising when deciding what to prioritize. Furthermore, the expert-led shift to problem-solving indexes the therapist's construction of the client as someone who needs assistance raises a paradox for meta-therapeutic dialogue. We can therefore conclude that the just-prior context for meta-therapeutic dialogue is on uncertain or shaky ground – even before we take into the account the implications of the therapist posing of a *question* (about what might be helpful) in response to the client's equivocal turn.

Let us turn now to the specific implications stemming from the therapist's posing of a *question* in the response space arising after the client's equivocal reference to a hoped-for state of affairs. The therapist's posing of a question at this juncture occurs in the place of other possible interventions, such as more substantively sharing their own ideas or suggestions with the client. Posing a question indexes a therapist-led move towards a problem-solving approach, but also an immediate stepping back by the therapist by refraining from helpfully supplying suggestions or other substantive content to the client. Therapists' questions to clients about what might be help can therefore be seen as at a least temporary rejection of the expert-therapist role and a postponement of the benefactive relationship in which one participant is constructed as being less able than another (Clayman & Heritage, 2014; Vehviläinen, 2003b). Thus, posing a question at this juncture shows the therapist working to establish more mutual roles and responsibilities in the relationship.

The therapist's question achieves this since it creates an unambiguous relevance for the client to share their ideas.

However, apart from creating an opportunity for meta-therapeutic dialogue, the therapist's stepping back from an expert role in posing the question has the potential to be treated as problematic by clients on a number of levels. In Chapters Seven and Eight, we will analyse how clients actually treat such questions from therapists. However, for now, we can discuss the interactional and relational implications of posing such questions after the client has produced an equivocal reference to a hoped-for state of affairs.

A key point here pertains to how the client's equivocal reference to a hoped-for state of affairs potentially works as an implicit request to the therapist for assistance (Pino, 2016). As we have seen, the therapist prioritizes the problem-solving – as opposed to the affiliative or empathic – relevance of the client's turn. However, in responding by posing a question, the therapist refrains from making suggestions or substantially assisting the client and, instead, creates an explicit relevance for the client to make suggestions and, in effect, to help themselves. Thus, immediately after the client has made it relevant for the therapist to respond helpfully, the therapist shifts the relevance for producing helpful responses back onto the client themselves. There is a face-work (Goffman, 1967) issue here, since it is already a potentially face-threatening move to even implicitly request assistance, without the recipient of the request then responding by suggesting that the request-maker help themselves. The use of a question to shift back the responsibility for producing helpful ideas could thus potentially be construed as a challenge to the client. Such a challenge might consist in an implication like that the client should already possess the relevant knowledge themselves.

Related to the idea of a question as a challenge is that of *known-answer* or *test questions* (Antaki, 2013). With test questions, not only is the questioner withholding the answer from the recipient, but they are also placing the recipient in a face-threatening situation by creating an on-the-record relevance for them to display knowledge – which they may or may not be able to do. Thus questions about what might be helpful in the context of clients' equivocal references to hoped-

for states of affairs can be seen to misalign and disaffiliate with the implicit request component of such turns. In effect, they withhold or refrain from helpfully responding to this implicit request and instead thrust the responsibility for knowing what might be helpful back onto the client. Test questions might be routinely expected within pedagogical settings (e.g. Mehan, 1979), however, the same cannot be said for therapeutic contexts. It is therefore relevant for pluralistic therapists to reflect on how they might minimize or address these concerns that their questions about might be helpful could be received by clients as being a 'test' or as a challenge, implying that the client should be able to know the answer and help themselves. Chapter Seven in the current thesis will detail how therapists can differently design questions about what might be helpful such that the implication of a test or challenge becomes more or less pertinent.

6.2.4.5 Potentially conflicting roles and responsibilities in meta-therapeutic dialogue One final clinically relevant consideration is how the therapist and client have been orienting to epistemic roles and responsibilities in the cases we have examined. Epistemic roles and responsibilities pertain to what material the client and therapist each treat as being within their knowledge domain, such that they can be expected to display this knowledge when requested (Stivers, Mondada & Steensig, 2011). How participants construct epistemic roles and responsibilities is especially pertinent in the context of pluralistic therapy which has been described as a radical departure from traditional roles of expert professional and inexpert client (Cooper & McLeod, 2011; McLeod, 2013). In the cases we have examined, we have noted the recurrent client practice of making an equivocal reference to a hoped-for state of affairs, such that this reference may or may not function as an implicit request. These equivocal references show clients displaying a lack of confidence regarding whether and how they might achieve their therapeutic goals.

In a study in a group therapeutic context, Pino (2016) noted how clients in a group meeting context made explicit requests for matters which it was straightforward for staff to provide and implicit requests when there were possible contingencies in granting the desired outcome. Kushida, Hiramoto and Yamakawa (2017) also showed how psychiatric outpatients make explicit (as opposed

to implicit) requests only if they also display that they know what the problem is, what can be done to solve it and that there is nothing they can do themselves to solve it. Although these other studies take place in somewhat different institutional contexts, they provide further grounds for conceptualizing the possibility that clients in the current data sample are making implicit requests for assistance with their problems since they are not certain about how much assistance the therapist can give. Perhaps clients might assume that their difficulties are insoluble or that it is not within the therapist's professional remit to offer advice or guidance. As noted previously, the therapist's posing of a question then nevertheless makes it relevant for clients to display knowledge regarding what might be helpful. In this way, similarly to Vehviläinen's (2003b) findings regarding counsellors' application of the principle of client self-directedness, we might anticipate a possible mismatch in how clients and therapists see their respective epistemic roles in displaying knowledge about what might be therapeutically helpful. Although client references to hoped-for states of affairs represent a topical bridge towards a discussion of what might be helpful, it may be that these references also show how the client is far from epistemically prepared to mutually engage in this discussion. Again, the question arises as to whether and how the pluralistic therapist can optimally facilitate the client to align with and participate in such a discussion. Chapters Seven and Eight will discuss these issues of practice in more detail.

Having explored some of the clinical issues arising when therapists pose questions about what might be helpful after clients have equivocally referred to a hoped-for state of affairs, we will now proceed to examine another interactional context in which therapists pose such questions.

6.3 Part Two: After client's minimal acknowledgement of therapist's perspective-display

Another context in which therapists pose questions about what might be helpful is after the client has just minimally acknowledged an extended turn from the therapist in which they have been displaying a perspective. In this context, the therapist introduces the question as an explicit shift to the topic of what might be helpful.

6.3.1 Part Two, Illustration 1: "oh yeah"

Extract SWAWGD occurs 20 minutes into the eleventh post assessment session. The therapist poses a question about what might be therapeutically helpful in lines 10-12.

Extract SWAWGD *Session#11/Start20minutes/PairC*

```
1   C:    ((continuing turn)) that's that's how I: dealt with it (.)
2         [↑↑they think-] thought it was quite funny
3   T:    [Yeah          ]
4   T:    Yea:h NO >I can iMAGine it was funny< but it CAN also be a way
5         of kinda keeping people at a distance ca[n't it.]
6   C:                                            [Yes-  ](.)°oh° ↓yeah.
7         (0.3)
8   T:    °Through humour.°
9         (1.1)
10  T:    .HH SO SO OKAY >so you're NOT GONNA go on=online< dating, (.)
11        so >what what are we gonna do< about °you: a:nd°
12        relationships.
13        (0.7)
```

The extract starts as the client ends their telling of how they handled particular interactions while on a night out (lines 1-2). In lines 4-5, the therapist agrees with the client that 'it was funny' and then contrastively assesses what the client was doing as 'keeping people at a distance'. The therapist then invites the client to agree with this contrastive assessment by producing a turn-final tag-question 'can't it'. The client minimally agrees, but does not take a more extended turn even though there are opportunities to do this in the pauses in line 7 and in line 9 after the therapist's increment. In line 10, after the 1.1 second pause during which the client does not take a turn, the therapist shifts topic by producing an upshot formulation of talk which is other than the just-prior talk. The upshot formulation refers to the client's aversion, stated earlier in the same session, to trying 'online dating'. This upshot constructs a relevant context for the therapist to then pose a question regarding how they can work towards the client's previously-agreed therapeutic goal of meeting a life-partner.

This question thus makes it relevant for the client to give ideas regarding what would be helpful in achieving this goal.

In Extract SWAWGD, the client just minimally agrees with the therapist's assessment of their actions even though there were opportunities (in lines 7 and 9) to display more substantial agreement or to disagree. In then shifting topic and posing the question about what might be helpful, the therapist acts as if the client is not now going to display any substantial views in response. Both this treatment by the therapist and the client's minimal agreement in the first place can be seen to jointly construct *topic attrition* (Jefferson, 1993) by treating the current topic as having been exhausted. The therapist then moves to pose the question which foregrounds a new topic and action agenda. This provides for the relevance of the client now giving ideas about what might be helpful or else explaining why they cannot. Either option requires the client to do something other than minimally respond.

In Extract SWAWGD, there is evidence that the therapist is using the question about what might be helpful to mobilize a more substantial response from the client after they have minimally responded to the therapist's perspective-display. This is since the question *qua* question sequentially constrains the client either to answer or to account for why they cannot answer. Either way, the question can be expected to secure more substantial participation from the client which would contrast with their minimal participation after the therapist's perspective-display.

Furthermore, the therapist produces this question as a shift to a new topic distinct from the one treated in the therapist's just-prior perspective-display. In so doing, the therapist thereby builds on the client's minimal response to construct a scenario of topic attrition by treating the previous topic as one about which there is nothing more to be said. Thus we here have a use of a question about what might be helpful which does more than simply open up an opportunity for meta-therapeutic dialogue. They also use the question to shift away from a previous topic (in this case an assessment or perspective-display from the therapist), which the client has not taken up an opportunity to substantially respond to.

6.3.2 Part Two, Illustration 2: "Mhm"

Extract TTH is taken from the assessment session and occurs 31 minutes in. The therapist poses a question about what might be helpful in lines 31-33.

Extract TTH *Session#0/Start31minutes/PairD*

```
 1  C:   ((continuing)) it's not something
 2       I- I particularly [wanna] enter ↑into again.
 3  T:                     [Ye:ah]
 4       (.)
 5  C:   [(Eh::m)    ]
 6  T:   [>But it SOU]Nds LIKE >the therapy work and >↓being in
 7       different kinds of therapies< is rea:lly rewarding for you=
 8  C:   =Yeah, I find it [incredibly (.) rew]arding, and- (.) good for
 9  T:                   [And really  (    )]
10  C:   my ↑↑health
11  T:   nYe:[:ah     ]
12  C:       [as well,] because you just .hh have to channel out
13       absolutely ↑all ↓your crap and just concentrate ↓on the person
14       in front of you .hh and I- °e-° .tch=
15  T:   =Ye[:ah    ]
16  C:      [Just th]ink it's wonderf(hh)ul
17  T:   Ye::ah .h >and I KINDa: I GUESS >one of the things about< °o-°
18       anxiety .h is often anxiety is about- that .h >tendancy to get
19       really focused in on somethi:ng< and you can get kinda: a ↑bit
20       lost in ↑things, .hh and the:n >then the question is whether
21       that's on something constructive< or: unconstructive. .hh like
22       that energy can either be: quite a negative thing >if it gets
23       really focused on your anxIETY< .hh but if it FOCUSes on
24       something positive like ↓you know doing something like therapy
25       we:ll then it can be a really positive .hh quality .h
26  C:    M:m
27  T:   °And ability to be able to ↑do:.°
28       (0.3)
29  C:   M:hm
30       (0.3)
31  T:   .HH So WHAT- >I mean IN TERMS of the THERapy here< what's
32       what's your: sense of it, wh=wh=wh: what's your thinking about
33       what you'd like to °do°.
```

Towards the beginning of Extract TTH, the therapist formulates the client's experience (lines 6-7) and the client displays extended agreement with this (lines 8, 10, 12-14 and 16). In lines 17-25, the therapist initially offers *pro forma* agreement ('yeah') with the client before shifting into a perspective-display (i.e. line 17: 'and I guess one of the things about…'), which consists of generally-applicable reports (e.g. line 18: 'often anxiety is about…') and assessments regarding two contrasting ways ('constructive or unconstructive', line 21) of managing anxiety. In lines 25 and 27, the therapist hearably ends their turn with a positive assessment of one of these ways of managing. This definitive ending then creates an opportunity for the client to display a perspective in response. However, after a 0.3 second pause in line 28, the client just minimally acknowledges the therapist's perspective-display (line 29). Another 0.3 second pause then ensues in line 30. This interactional space in lines 28 and 30 and the client's minimal acknowledgement show the client not taking up an opportunity to display a perspective in response to the therapist's perspective-display. The therapist then goes on to pose a question in lines 31-33 concerning what the client would like to do in the therapy.

Extract TTH is similar to Extract SWAWGD in several key respects: The client has not taken up an opportunity to display a perspective in response to a perspective display from the therapist (lines 28-30). Both the client's non-uptake and the therapist's subsequent shift to pose a question about a new topic then construct apparent topic attrition after the therapist's perspective-display. The therapist's posing of a question at this point will most likely now also mobilize more substantial participation or a non-minimal response from the client. Thus again we see how the therapist can pose a question about what might be therapeutically helpful to achieve other interactional outcomes aside from creating an opportunity for meta-therapeutic dialogue. These other interactional outcomes include using a question about what might be helpful to launch a new topic which moves on from a perspective-display from the therapist which the client has not substantially responded to. Furthermore, this question about a new topic also works towards securing more-than-minimal participation from the client in the upcoming talk.

6.3.3 Clinically-focused discussion

In the cases examined in Part Two, the therapist follows up the client's minimal acknowledgement of the therapist's views (i.e. perspective-display) by switching to the new topic of what might be helpful. This illustrates another interactional use for questions about what might be helpful. In the event of apparent topic attrition or trailing off of a previous topic, the therapist can use a question about what might be helpful to open up a new topical focus for the interaction. In this sense, these questions work as a strategy for substantially involving clients in a new activity after they have been minimally participating regarding the previous topic.

Aside from this apparently straightforward use of questions about what might be helpful to open a new topic and activity, there may also be another, more subtle process in some of these cases. This process relates to the client's minimal acknowledgement of the therapist's perspective-display, which the therapist subsequently treats as topic attrition. An alternative move from the therapist in this scenario would be to pursue a more substantial response from the client regarding what their views on the therapist's perspective-display. However, in the cases we have examined, the therapist here does not pursue more than a minimal response but instead moves on to open a new topic by posing a question about what might be helpful. In doing so, the therapist prioritizes creating this new topical focus over pursuing a more substantial response from the client. The therapist thus foregoes the opportunity to encourage the client to be less reticent or to check for possible resistance from the client to the therapist's just-prior perspective-display. As noted by Heritage and Sefi (1992), minimal responses to the professional's perspective-display are treated by participants as indexing resistance to the professional's advice. In the cases we have examined, it is possible the clients' minimal acknowledgements of the therapists' perspective-display may also be displaying some interactional resistance to fully endorsing it. An exploration of this possibility could potentially open up the client's own material in relation to the therapist's perspective-display. However this other therapeutic relevancy is de-prioritized when the therapist instead shifts to a new topic by posing a question about what might be helpful. Thus, posing such questions as a new topic may be used by therapists to de-prioritize or avoid investigating cases of reticence and possible

resistance on the client's part. In this way, posing a question to raise the topic of what might be helpful can also be considered to *reset* or move on the interaction from these scenarios of client reticence and potential resistance and/or disagreement.

In my analysis of how the therapist can pose a question about what might be helpful as a new focus, I have described, in non-evaluative terms, what is involved in such a move. It is, of course, possible that this move could be used in more or less therapeutically beneficial ways. It comes down to the individual therapist's judgement as to whether it is now a priority to guide the talk towards a focus on what might be helpful as opposed to further pursuing the current focus and unpacking the client's minimal responses to the therapist's perspective-display. However, it remains the case that in posing a question about what might be helpful as a new topic without first pursuing a more substantial response from the client, the therapist may be neglecting or avoiding other dialogic opportunities, for example, by offering the client an opportunity to display disagreement or to offer some qualification of the therapist's perspective-display (Barnard, Cruice & Playford, 2010). The missing of such an opportunity would be the case even if the new topic about what might be helpful also offers opportunities for meta-therapeutic dialogue. Strikingly, even when questions about what might be helpful seem to be working *prima facie* to create more explicit opportunities for the client to give their views, the same questions may also be used to avoid other possibly more uneasy opportunities for dialogue or meta-communication. This practical dilemma of what the therapist may be neglecting or avoiding when posing a question about what might be helpful – and the associated benefits, or otherwise, to the therapy – is one which it would also be beneficial for practitioners to engage with.

6.4 General discussion

Therapists' questions to clients about what might be helpful create an explicit opportunity for the client to give ideas and thereby enter into meta-therapeutic dialogue. In this way, such questions are one site at which therapists can be clearly seen to adhering to recommendations for doing pluralistic therapy. This chapter has examined two interactional contexts in which therapists pose questions

about what might be helpful to clients. In the first context, examined in Part One, the therapist posed questions about what might be helpful immediately or soon after the client has equivocally referred to goal-relevant material. In Part Two, we also saw how the therapist can use a question about what might be helpful to change to a new topic after the client has just minimally acknowledged a perspective-display by the therapist.

At the end of Part One, we discussed several clinical implications of the therapist posing a question about what might be helpful after clients' equivocal references to goal-relevant material. One implication concerned how posing such questions inherently requires the therapist to prioritize doing so over other therapeutic relevancies such as empathically and affiliatively responding to the affective components of the client's turn. We also noted a fundamental paradox in creating opportunities for meta-therapeutic dialogue, since the therapist's very act of expertly moving the talk towards what is essentially a problem-solving framework has less than mutual implications. This lessening of mutuality occurs since the shift towards discussing what might help the client constructs them as the less-knowing member needing assistance. As we have discussed, such a construction can be face-threatening and, furthermore, the posing of a *question* as a means of implementing this shift also creates a possible mismatch in terms of participants' treatment of their respective epistemic roles and responsibilities. The issues of prioritization, a lessening of mutuality, face-threat and mismatched epistemic responsibilities all indicate the importance of the therapist carefully working to achieve the move towards meta-therapeutic dialogue in a way which makes it acceptable and relevant for the client to align with and participate in. As noted by Strong, Pyle and Sutherland (2009), such a move requires relational as well as rhetorical work.

In Part Two, the questions about what might be helpful occur in quite a different context to those in Part One. The cases in Part Two differ from those in Part One since the client has *not* just previously referred to goal-relevant material. Instead, the therapist has been displaying a perspective which the client has just minimally acknowledged. In Part Two therefore, the therapist poses the question as a new topical focus rather than one which builds on the client's just-prior talk. Despite the differences across these two contexts, the cases in Part Two contribute to further

supporting and elaborating the clinical implications discussed for Part One. For example, we noted how the therapist's posing of a question in Part Two involves prioritizing introducing talk about what might be helpful as a new topic and a concomitant lack of focus on exploring the client's reticence. This supports the finding in Part One that creating an opportunity for meta-therapeutic dialogue involves a concomitant de-prioritizing of other therapeutic relevancies, which in the case of Part Two would consist of exploring the client's reticence and the possibility that they are resisting endorsing the therapist's perspective-display. Another clinical implication developed by the findings in Part Two concerns the relational impact of the shift towards meta-therapeutic dialogue – specifically in this case, the impact of leaving the client's reticence unexplored and moving on to introduce the new topic of what might be therapeutically helpful. There are several possible relational consequences of such a move – although the precise configuration of consequences will vary for any particular case. These possible consequences include the postponement of discussing the client's here-and-now views and experiences of the therapy and the possibility that the client will continue to be reticent or also interactionally resist this new focus of what might be helpful.

In summary, comparing the cases across Parts One and Two illustrates the range of contexts in which therapists can pose questions about what might be helpful as well as the therapeutic issues which tend to re-occur across cases. One take-home message from the findings of the current chapter is that creating an opportunity for meta-therapeutic dialogue impacts on the therapeutic relationship since this action necessitates prioritizing this therapeutic relevancy over others. Questions are an effective means of achieving this prioritizations since "As long as one is in the position of doing the questions, then in part they have control of the conversation" (Sacks, 1995, p.54). However, the relative directiveness of this prioritization also means that therapists need to invest in relationship management when working to create opportunities for meta-therapeutic dialogue. A second take-home message is that, as with any conversational action, therapists' explicit manoeuvres towards meta-therapeutic dialogue may be doing additional work. Minimally, such additional work involves the de-prioritization of various other therapeutic relevancies, but this prioritization can also involve the avoidance of other meta-communicative or dialogical

opportunities or a move to shut down the clients' troubles-telling turns. In order to ensure maximal therapist awareness and considered, appropriate responsiveness to what the client brings, there may be a need to sensitize practitioners to this additional work that their move towards meta-therapeutic dialogue may be performing.

A general issue for pluralistic therapy, raised by the findings of the current chapter, concerns the multi-dimensional nature of the pluralistic therapist's role – resulting in response spaces in which the therapist can respond by prioritizing one of several different therapeutic relevancies. For example, as illustrated in Part One, it is potentially open to the therapist to prioritize either the empathic or the problem-solving relevancies and, indeed, both are official components of the pluralistic therapist's job description, in combining humanistic, person-centred and goal-oriented approaches. This issue of competing relevancies facing the pluralistic therapist ties into a larger issue of possible inherent ambiguities of how therapeutic services are actually implemented. On the one hand, many counsellors and therapists, including pluralistic ones, are supposed to respect and facilitate the client's process at the client's own pace, and yet, on the other, the therapist may have some knowledge and expertise which the client could benefit from if shared with the client (Vehviläinen, 2003b). As discussed by Butler et al. (2010), even call-takers with an explicit person-centred mandate, still work to produce more directive, advice-like content e.g. *advice implicative interrogatives*. The findings from Chapters Seven and Eight propose a possible conceptualization for how therapists can manage the competing relevancies of facilitating the client's expertise and own directions while also appropriately and expertly managing the therapeutic direction of the interactions.

A conceptual issue for pluralistic therapy arising from the current findings is that aside from the theoretically-informed construal of therapists' questions about what might be helpful as *creating an opportunity for meta-therapeutic dialogue*, the interactional features of these questions are highly reminiscent of that noted by other CA researchers, which is an observable shift from prioritizing empathic, affiliative relevancies towards prioritizing task-based, problem-solving agendas (e.g. Ruusuvouri, 2007). Thus, as in Chapter Five, we return again to the conceptual issue of whether

there is any substantial practical distinction between meta-therapeutic dialogue about therapeutic methods and structured problem-solving approaches. This issue of a practical distinction might be obscured by my inclusion criteria for questions about what might be helpful (cf. Chapter Five), since I included both more general, process-focused questions and questions focused on a specific issue or goal. These more specific issues might be considered as examples of more conventional structured problem-solving approaches. However, Extract TTH in the current chapter (Section 6.3), is an example of a more process-focused question, which still follows the interactional practices noted across the collection. The same is true for the cases shown in Chapter Seven. We will return to this issue again in Chapter Nine.

6.4.1 Limitations

The analyses in the current chapter have focused in-depth on two interactional contexts in which therapists pose questions about what might be helpful. However, this in-depth focus occurs at the expense of describing a greater variety of contexts in which therapists pose these questions. My rationale for this focus was that there were several complex considerations arising for practice, which it would be beneficial to treat them in-depth. Furthermore, the considerations for the context investigated in Part One of this chapter seemed to apply to several other of the contexts in which therapists pose these questions and so it seemed like a worthwhile one to prioritize. A final reason for prioritizing an in-depth treatment was since this would work towards the current research aims of contributing towards bridging the practice-research gap by fully illustrating the complexities of attempting to practice both in a goal-oriented as well as in a dialogical manner.

The analyses in this chapter are further limited by the focus on the just-prior context as opposed to also considering the interactions occurring for a greater length of time before therapists posed the questions about what might be helpful. For example, conceivably the current research aims could also have been fulfilled by considering how these questions followed on from all of the preceding activities and sequences in each session. Such a more longitudinal focus would indeed be a candidate for future research, but it would be extremely time-consuming especially given that

participants do not tend to structure psychotherapy sessions as much as in some other institutional encounters such as medical interactions (Peräkylä, 2013).

As indicated in the extract labels, the extracts in this chapter are all taken from one qualified therapist's one work across two different clients. These extracts were selected since they seemed particularly evocative of the considerations arising when therapists practice pluralistically. A possible limitation of this selection is that practices described might be specific to this one therapist. However, I would make the claim that the broader considerations arising for the practice of pluralistic therapy remain valid.

6.4.2 Relevant future research

Across these implications for training, the general issue arises as to what therapists can do to ensure that opportunities for meta-therapeutic dialogue are as accessible and as encouraging as possible for clients to substantially engage with. Chapter Seven will investigate this issue through an in-depth comparison of different ways in which therapists can design questions about what might be helpful and how clients respond to these. However, this issue would also benefit from further observational research. For example, are there instances in which this switch between empathic and problem-solving relevancies can form part of a more mutual relational process? What would such instances look like?

The reoccurrence, across clients, of equivocal references to hoped-for states of affairs or goal-relevant material also warrants some further research. It is clinically significant that one potential ground upon which to build opportunities for meta-therapeutic dialogue comprises an initially ambiguous of mix troubles-telling and some content which is a bit more goal relevant. One possibility is that these turns are a culturally normative means of engaging in talking about problems as a client. In this case, it makes sense to further examine the nuances and sequences of such talk and to sensitize therapists to it and to encourage them to reflect on various means of responding therapeutically to this talk. Another possibility is that there may be some extra-discursive, therapeutic and psychological processes involved. For example, perhaps the client is attempting to

save face here by doing being a 'good client' and referring to their goals in a therapeutically-relevant manner, so that they cannot be accused of only complaining. Of course, further research is required to definitively investigate what extra-discursive processes might be relevant here. A relevant research model to follow or extend in this instance might be the narrative-based coding systems developed out by Gonçalves et al. (2016), which include a coding system of displays of client ambivalence. In another relevant research stream, Lømo, Haavind and Tjersland (2016) analysed clients' talk into *gateway themes* which potentially opened up paths to developing the working alliance. They evaluated each theme in terms of whether it represented a relatively stronger or weaker invitation from the client. In the strongest invitations, the clients were *task-focused* in searching for new alternatives and *inward-focused* in their reflections. Clients' equivocal references to hoped-for states of affairs, as highlighted by the findings in the current chapter, could also be further investigated using these conceptualizations. Such research could be beneficial in terms of sensitizing therapists to endorse and highlight strong invitations from clients. Such interventions would further link with existing resource-oriented conceptualizations of clients (e.g. Bohart & Tallman, 1999).

As reported in Chapter Five, therapists rarely posed questions about what might be therapeutically helpful in the current sample of sessions. It is an open empirical question as to whether or not therapists more frequently posing such questions would result in a greater amount of meta-therapeutic dialogue and presumably more effective collaborative personalization of the therapy. As anticipated by the findings in the current chapter, questions about what might be helpful are observably fulfilling the recommendations of pluralistic therapy, but at a cost, which is the prioritization of foregrounding meta-therapeutic dialogue over responding to other therapeutic relevancies or client needs. Thus, an alternative possible prediction is that consistent prioritization of this kind involved in posing questions about what might be helpful might lead to *deterioration* in the therapeutic relationship, since it would involve a de-prioritization of other therapeutic and relational relevancies. The untangling and testing of such predictions is another clinically worthwhile and relevant avenue for future research studies.

6.4.3 Position and contributions to CA literature

Therapists' non-explicit prioritization of therapeutic foci through actions such as formulations and questions has previously been highlighted by Antaki (2008) and others (e.g. Muntigl et al., 2014; Voutilainen, 2012). Most recently, Ekberg et al. (2016) have considered how therapists' orientations to clients' emotions in online, text-based therapy could actually preface a move away from a sustained focus on these emotions. This is a striking finding in terms of showing that what therapists are ostensibly doing (focusing on emotions) can actually also facilitate a movement away from this very activity toward one less focused on emotions etc. The findings of the current chapter can be situated within this research stream and further support the broad finding that such prioritization is inherent in therapeutic interactions *qua* human interaction. The current findings also extend this research stream by illustrating how therapists can engage in such prioritization through the achievement of ostensibly dialogical activities such as questions about what might be therapeutically helpful. Furthermore, the current findings demonstrate publicly-available interactional evidence regarding how professionals, such as therapists, might work to avoid the client potentially disagreeing or resisting, while still ostensibly creating a dialogic opportunity.

The current findings also relate to Strong, Pyle and Sutherland's (2009) CA-informed treatment of *scaling questions* as one practice in Solution Focused Brief Therapy, since both studies focus on detailing solution-focused/problem-solving questions on a moment-by-moment basis. Strong, Pyle and Sutherland explicate examples of this practice without necessarily trying to identify features which re-occur across examples. My findings build on theirs, firstly, by exploring another distinct type of questioning practice and, secondly, by attempting to evidence key features of this which re-occur across client-therapist pairs, such as two contexts in which therapists pose these questions. I will continue this analysis across cases in Chapter Seven by providing evidence for some re-occurring features concerning the design of these questions. In both the current chapter and in Chapter Seven, I also outline a range of specific implications for practice, which go beyond the broad implications indicated by Strong et al.

The current findings can also contribute to ongoing CA research interests by furnishing some illustrations of implicit requests in institutional settings to add to those described by Kushida, Hiramoto and Yamakawa (2017) and Pino (2016). All of these studies represent a relatively recent analytic focus on how participants can make an indirect request regarding a problem or need which is *remote* from the here-and-now interaction. This analytic focus runs conceptually parallel to Kendrick and Drew's (2016) recruitment continuum, which conceptualizes how explicitly help was recruited by the recipient, for example, using requests, reports, alerts and embodied displays. There is a conceptual similarity between the aforementioned studies of implicit requests and Kendrick and Drew's category of when help was recruited by reports of need or difficulty. This is since both reports of need which is here-and-now and reports of a need which is beyond the here-and-now or remote, create an opportunity – rather than an obligation – for the others to volunteer assistance. However, as noted by Heritage (2016), there are likely also distinct affordances when recruiting assistance for here-and-now problems compared to more remote ones. The illustrations in the current chapter, alongside findings from Kushida, Hiramoto and Yamakawa (2017) and Pino (2016) may represent an early step towards starting to articulate what these distinct affordances might consist of.

Chapter Seven: How therapists design questions about what might be helpful

7.1 Chapter overview

As discussed, in the current thesis, I am treating therapists' questions about what might be therapeutically helpful as one way in which the therapist can invite the client to give ideas and thereby participate in meta-therapeutic dialogue.

In Chapter Six, we compared different contexts in which therapists pose these questions. The current chapter will now comparatively analyse how therapists design or package these questions and how clients respond. My analysis identified three different ways in which therapists design these questions. These designs are distinguished in terms of the different relevancies they set up for client responses and in terms of how clients generally respond. The central finding of this chapter is that, in designing these questions, therapists orient to a practical dilemma between making it easier for the client to answer the question while still also encouraging the client to respond with their own ideas. These findings have been submitted for publication by Cantwell et al. and are currently under peer review.

One of the inclusion criteria for questions about what might be helpful was particularly relevant in undertaking the analyses reported in this chapter and in Cantwell et al. (submitted). This was Criterion 2, which we discussed in Section 5.5.2 of Chapter Five. This specified that for a question to be included in the current collection, there must be evidence that participants are treating it as having the basic interactional constraints associated with questions; namely, when the question is posed, the recipient must either furnish an answer or else explain why they cannot answer. In the current chapter, I will refer to this constraint as one response requirement which becomes relevant when the therapist poses the question. My analysis will demonstrate how, when designing questions about what might be helpful, therapists orient to a need to soften this and other response requirements to a greater or lesser degree.

The first design we will consider is a *minimally softened* one that only slightly mitigates the response requirements facing the client. The second is a *substantially softened* design, which incorporates features to mitigate these response requirements to a large degree. The third way is a

softened and de-specifying design, which firstly mitigates the requirements before subsequently, in the same conversational turn, inviting the client to extend their response beyond these mitigated requirements. In order to illustrate the clinical relevance of the current analysis, I will also engage in clinically-focused discussion of each of the three question designs and the practical dilemma arising.

This analysis in terms of three ways of designing questions about what might be helpful exhaustively covers the design of all 28 cases in the current collection. I will discuss the frequency of these designs across cases in Section 7.5.

7.2 Minimally softened design

We will now examine two questions about what might be helpful, for which the therapist *minimally softens* the requirement for clients to answer. This softening can be considered minimal since the therapist incorporates several other features of the question design which heighten the relevance of the client answering immediately with their own ideas.

In this section, the evidence that participants treat this as a minimally softened design stems from how clients respond to such questions. Further evidence will be provided in the next sections (7.3 and 7.4) of this chapter, in which I will develop a comparative analysis of a different way of designing these questions.

7.2.1 Illustration 1: How can you do that?

Extract HCYDT is taken from 30 minutes into the second post-assessment session. The therapist poses the question about what might be helpful in line 36: ">And I guess< and ↑how- ↑how can you do that?"

EXTRACT HCYDT *Session#2/Start34minutes/PairD*

```
31  C:    [>I want it to] be the ↑#other #way #ar↑ound<
32  T:    [Ye:ah        ]
33  C:         SHHih. HHHEHH[h ]
34  T:                      [Ye]:ah
35  C:         hh. .shhih
```

```
36  T:   h. >And I guess< and ↑how- ↑how can you do that?
37  C:   °.shhhih M::m,° (0.8) °°brain transpl[ant°°  ]
38  T:                                          [hehheh] [heh hahhah] hah
39  C:                                                   [hih ha hah]
40  C:   °Oh God° .hh hh (0.8) °I dunno:°
41       (1.0)
42  C:   ↑Being in a state of hypervigilence all the ↑time, and then
43       sitting down and examining every emotion and .hh whether it's
44       valid or just (.) non↑sense? .hshih °°that sounds°° a hell of
45       a lotta wo[rk.]
46  T:             [It ]does doesn't i:t?
47  C:   °Uh ha:h° >but it's<- it #actually sounds quite
48       necess(hh)AR(hih)Y wo(hhh)rk. (.) .shhih
```

The therapist poses this question about what might be helpful immediately after the client has ended their turn with an equivocal reference to a hoped-for state of affair, ">I want it to be the ↑#other #way #ar↑ound<" (line 31). As previously discussed in Chapter Six, this reference from the client may be an implicit request and thereby makes a helpful response from the therapist possibly relevant (Butler et al., 2010; Pino, 2016). However, in posing a question about what might be helpful, the therapist instead prioritises inviting the client's own ideas.

Moving now from the above contextual considerations to focus on how therapist has designed this question, there is some evidence that the therapist is displaying that this question might be problematic in this context. For example, the therapist delays the production of the question in several ways, including their repair of ">And I guess<" into "and ↑how-" and their cut-off of the first "how-" before re-issuing it and finally producing a complete question: "how- ↑how can you do that?" With this halting design, the therapist here treats the question as an action which is non-straightforward and potentially problematic for the client in the current context (Drew et al., 2013; Silverman & Peräkylä, 1990). Furthermore, they use "I guess" which slightly mitigates the relevance of the question by constructing it as a tentative action proposed from the therapist's perspective and which is not presumed to be straightforwardly relevant for the client (Silverman & Peräkylä, 1990; Strong & Sutherland, 2007). This projection of problematic treatment amounts to a

minimal softening of the response requirement facing the client since it may implicitly give the client licence to enact the problematic treatment of the question in their response.

However there are other aspects of the question which crosscut with the therapist's minimal softening of the response requirements. Firstly, the therapist poses the question so that it becomes relevant for the client to respond by independently producing content. For example, in selecting the *wh*-question word "how", the therapist leaves open the field of response for the client to independently produce content regarding ways to "do that" (Clayman & Heritage, 2002). This *wh*-question is also structurally simple, that is, without addendums like suggestions or extensions and with minimal re-doings. This is a further way in which therapist treats the requirement to independently produce relevant content as one about which the client is knowledgeable and capable of doing independently – unassisted by any candidate answers or refinement of the question by the therapist (Pomerantz, 1988; Heritage & Raymond, 2012). Taken together, these features of the simple *wh-question* format encode the presupposition that the client is able to independently supply an answer (Stivers, Mondada & Steensig, 2011; Pomerantz, 1988; Boyd & Heritage, 2006). The short, simple *wh*-question format also makes it relevant for the client to answers immediately, since it provides no buffer between the question and the point of response relevance.

In sum, the question makes it relevant for the client to produce content independently and immediately or else to explain by they are not doing so. However, as we have seen, these response relevancies are crosscut by the minimally softened aspects of the design which might implicitly give licence to the client to respond by treating the question as problematic. In the next section, we will move on to consider how the client responds to this *minimally softened* question about what might be helpful.

7.2.1.1 Client's response In Extract HCYDT, the client responds by treating the question about what might be helpful as problematic. First of all, in line 37, their turn-initial sniff ".shhhih", the floor-holding "M::m", and 0.9 second pause all contribute towards delaying the response. This delay

shows some kind of problem or difficulty in responding. The client then whispers “brain transplant”, a non-serious answer referencing a practically impossible solution. This non-serious answer minimizes, and thus misaligns with, the question agenda (Muntigl & Horvarth, 2014). In lines 38-39, the therapist and the client then engage in laughter regarding this non-serious response, which shows their affiliative co-management of the client’s misaligning and problematic treatment of the question about what might be helpful. However, in line 40, the client resumes their misaligning response by producing an explicit display of difficulty, involving the complaint-element “°Oh God°”, further delay, “.hh hh (0.8)”, and the prosodically emphatic claim that they do not know. There follows a 1.1 second pause (line 41). The display of difficulty and subsequent lack of action from the client shows that they are, to some degree, holding the therapist responsible for their inability to answer (Keevalik, 2011). The implication is that the therapist has posed a question which is problematic for the client to answer. This thereby represents a disaffiliative moment in the client’s treatment of the question (Keevalik, 2011).

After the 1.1 second pause during which the therapist also does not take a turn, the client then re-aligns with the question agenda by providing an apparently more serious answer (lines 42-44), starting with: “↑Being in a state of hypervigilence all the ↑time, and then...((continues))” However, the client constructs this apparently more serious answer as impossible to implement. They achieve this construction-as--impossible by interspersing their answer with complaint-elements, including emphatic and raised intonation, extreme case formulations (e.g. “all the ↑time”, “every”), the pejorative term “non↑sense” and a turn-final negative assessment, “that sounds a hell of a lotta work”. In the context of the client’s recent non-serious answer of “brain transplant” (line 37) and their disaffiliative display of difficulty in line 40, the client’s construction of their answer as practically impossible is hearable as further disaffiliating with the question agenda of their giving ideas about what might be helpful. In providing an answer, the client has aligned with the agenda, but in a disaffiliative manner almost to the point of producing a *reductio ad absurdum* of the question. Thus this non-serious answer also indexes the client’s continuing treatment of the question about what might be helpful as problematic. In lines 47-48, the client does move to re-

affiliate with the question agenda ("Uh ha:h° >but it's<- it #actually sounds quite necess(hh)AR(hih)Y"). I will consider this move to re-affiliate in detail in Chapter Eight when considering how therapists manage the aftermath of clients' responses to questions about what might be helpful. However, for the purpose of the current analysis of how therapists design these questions and how clients respond, it is relevant just to note how the client initially treats the therapist's *minimally softened* question about what might be helpful as highly problematic.

In summary, in Extract HCYDT, the therapist produces what I am labelling a *minimally softened* question about what might be helpful after the client has made an equivocal reference to a hoped-for state of affairs. While this *minimally softened* question design may implicitly give licence to the client to misalign by treating the question as problematic, it still endorses the relevance of the client immediately and independently answering. The client responds by initially misaligning and disaffiliating and treating the question as highly problematic. The client achieves this through producing non-serious content, claiming not to know and implicating the therapist's responsibility for having asked a difficult or problematic question.

7.2.2 Illustration 2: What would be the best way of dealing with it?

To further illustrate how therapists produce the *minimally-softened* design, I will now examine another case of this and how the client responds. Extract BW is taken from 22 minutes into the second post-assessment session. The therapist poses the question about what might be helpful at lines 25-26: ".Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the- best (0.3) way °of dealing with=it.°"

As illustrated in Chapter Six, posing the question at this point shows the therapist prioritizing problem-solving over displaying empathy after the client has equivocally referred to a hoped-for state of affairs. Furthermore, the therapist poses this question at a particularly multi-faceted point when they are somewhat misaligned regarding the current interactional focus. For example, the therapist has just produced a pivotal formulation (lines 20-21) which works to close down the client's troubles-telling and prepare for the posing of the question as a relevant action. As discussed

in Chapter Six, this question in this context raises the possibility that the client will treat it as face-threatening or as otherwise problematic.

Extract BW *Session#2/Start22minutes/PairD*

```
12  C:   >and I wa:nt< to (0.3) de:al w#ith h (0.3) ↑THIS bit that's
13       coming .hh in the: most construct[ive  l]east energy expe(h)n-
14  T:                                    [°yeah°]
15  C:    least emotional en(h)er#gy ex(h)p#ending way .hh °°cause I
16        just°° feel so exhau:[sted      ]
17  T:                         [↓Yeah I  b]et
18       (0.4)
19  C:   [I          ↓re::::ally          ] [↓(no:w)    ]
20  T:   [°We°'ve both been >talking about] [it and think]ing about it<
21       all the t[ime, and=it's] >going round and round in your ↓head<
22  C:            [Yeah=h       ]
23       (0.3)
24  C:   °Ye:ah°
25  T:   .Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the-
26       best (0.3) way °of dealing with=it.°
27  ?:   .hh °.shih°
28       (6.0)
29  ?:   .PT
30       (1.2)
31  T:   >It's UNpredictable >and it's a difficult
32       [question isn't=↓it=cause (th-)] .hh you- >DON'T KNOW WHAT HIS
33       ((continues))
```

The therapist's design of the question about what might be helpful in Extract BW includes perturbations (e.g. "°umph°"), cut-offs (e.g. four in Line 25: "w-:OUld- b:e- (.) the-") and gaps (e.g. 0.3. seconds in line 26). These features work to delay the production of the question and thereby display that the therapist is treating this action as somewhat problematic in the current context (Silverman & Peräkylä, 1990; Strong & Sutherland, 2007). As in Extract HCYDT, this delayed and problematic production can be considered to minimally soften the response requirements facing the client since it gives some implicit licence to respond by treating the question about what might be helpful as problematic.

Again similarly to Extract HCYDT, despite the minimal softening effected by this delayed and problematic production, the therapist otherwise designs the question to support the relevance of answering immediately and independently with their own ideas. For example, the therapist's formats it as a simple *wh*-question: ".Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the- best (0.3) way °of dealing with=it.°" As detailed in the analysis of Extract HCYDT, the *wh*- format encodes the presupposition that the client is sufficiently knowledgeable to independently produce content regarding what might be helpful (Heritage & Raymond, 2012). This presupposition is further embedded by the simple format which does not incorporate any re-doings or candidate answers, thereby treating the initial question as one which can be unproblematically and independently answered by the client. Furthermore, the brief nature of the *wh*-question format and no post-interrogative material means that the client is required to immediately respond.

The therapist's design of the question about what might be helpful here also constructs it as a straightforwardly relevant action. For example, in wording the question, the therapist uses a version ("dealing with") of a phrase the client has used in their recent extended turn ("de:al w#ith", line 12). This recycling by the therapist implies a connectedness between the client's concerns as described in their recent extended turn and the question agenda (Peräkylä, 2004a; Weiste & Peräkylä, 2013; Emmison, Butler & Danby, 2011). In addition, the therapist uses a simple *wh*-question format, thereby treating it as an action requiring no explanation or account as to why the therapist is posing it at this point (Peräkylä, 1998; Parry, 2009). By constructing the question about what might be helpful as a straightforwardly relevant action, these design features also support the requirement for the client to independently respond.

Finally, the therapist's question about what might be helpful also specifies that the client should produce content regarding the "the- best (0.3) way °of dealing with=it°". The superlative nature of the adjective "best" presupposes that there is an optimal "way of dealing with=it°". So this further presupposes the client is knowledgeable regarding an optimal "best (0.3) way" and can independently produce content about this. Indeed, it might be argued that this use of a superlative crosscuts the therapist's use of "would" as the auxiliary verb in the question, which, as Ekberg and

LeCouteur (2014a) noted in their study, might have softened the response requirements by inviting more hypothetical suggestions as opposed to immediately feasible ones.

In summary, the therapist in Extract BW poses the question about what might be helpful at a point where the client and therapist are not yet aligned regarding the focus of the current interaction. This is due to the therapist's prioritization of the question over other possible therapeutic relevancies. The therapist minimally softens the response requirement with a perturbed and halting production of the *wh*-question. However, aside from this minimal softening, there are several other features of the question about what might be helpful which fully endorse and accentuate the relevance of the client responding, including the bare production of a simple *wh*-question and the associated presupposition that the client can immediately and independently answer and, finally, the construction of the question as a straightforward and superlatively-focused action. These features illustrate the crosscutting nature of the minimally softened design, such that on the one hand, the therapist is orienting to some problem in producing the question about what might be helpful, while on the other hand, they include features which work to fully endorse the requirement for the client to more than minimally respond.

7.2.2.1 Client's response As outlined above, the client in Extract BW is faced with the question about what might be helpful as an action to which it is now immediately and highly relevant for them to respond. After the therapist poses this question, there is a pause of almost 8 seconds (lines 28-30), which is unusually long in the current data sample. In this pause, the client does not verbally respond to the question. It seems plausible that they respond non-verbally at some point(s) during the pause, but the audio-recordings in the current study do not allow access to this non-verbal data. Whatever the client's non-verbal responses might be during the pause, the therapist also contributes to the pause by withholding from speaking. In doing so, the therapist maintains the relevance of the client responding to the question, and so, can be seen to be non-verbally pursuing an answer from the client (Muntigl & Zabala, 2008). The lack of a verbal response from the client and the therapist's withholding from speaking creates an interactional impasse which both

participants allow to build for almost 8 seconds. This impedance of progressivity provides evidence that the client is treating the therapist's posing of the question about what might be helpful as highly problematic.

In Extract BW, the client's treatment of the question about what might be helpful as problematic occurs after the therapist poses a *minimally softened* question in response to the client's equivocal reference to a hoped-for state of affairs which may also function as an implicit request. The superlatively-focused enquiry of the question accentuates the response requirements facing the client, and even more so after the client has possibly just made an implicit request. It seems likely that these contextual features, alongside the question's endorsement of the above-mentioned response requirements, combine to pave the way for the subsequent lack of verbal response from the client. This shows that the client is treating the question about what might be helpful as a problematic action in this context.

7.2.3 Clinically-focused discussion

As illustrated in Extracts HCYDT and BW, the clients initially treated minimally softened questions as problematic. This is also overwhelmingly so for the other cases of questions about what might be helpful in the current collection. This treatment as problematic involves various forms of misalignment with the question agenda, and disaffiliation with the therapist, including resisting the presupposition that they can answer by claiming a lack of knowledge, withholding a verbal response entirely, constructing answers as non-serious or impracticable and, at least temporarily, implying that the therapist might be responsible for having posed a problematic question. This treatment as problematic by clients shows a lack of common ground between therapists and clients regarding minimally softened questions about what might be helpful. In particular, clients' misaligning and disaffiliative responses create a mismatch between therapists and clients regarding whether the client should be expected to have their own ideas about what might be therapeutically helpful. Stivers, Mondada and Steensig (2011) describe such expectations as the epistemic roles and responsibilities which participants orient to in interaction.

The design of minimally softened questions may also show therapists orienting to this mismatch in expectations about who should know and the corresponding roles and responsibilities. In particular, the crosscutting of softened elements with other elements which make relevant an immediate, independent answer shows therapists orienting to conflicting demands in posing such questions (Drew, Walker & Ogden, 2013).Using an interaction-far, conceptual lens, posing questions to provide clear opportunities for clients to offer ideas seems like an obvious way to create opportunities for meta-therapeutic dialogue. However, at the interaction-near, local level, we can see how therapists project, with crosscutting question designs, that posing these questions is not a straightforward matter (Silverman & Peräkylä, 1990).

The developers of pluralistic therapy have acknowledged difficulties in securing clients' participation in meta-therapeutic dialogue (e.g. Cooper et al., 2016; Cooper & McLeod, 2011; McLeod, 2013) (cf. also Chapter Two). However, interestingly, these acknowledgements focus on the challenges facing the client, such as deference (Rennie, 1994), without also acknowledging the intricacies of the interactional task faced by therapists in trying to secure clients' participation. In the remainder of this chapter, my analysis will continue to articulate these intricacies with a view to further bridging the practice-research gap around meta-therapeutic dialogue. Even from just this first part of the analysis, we have seen how the minimally softened design, with a simple *wh*-question and sparse ancillary trimmings, occurs alongside a publicly observable mismatch between participants regarding what the client's role is. Should they be able to answer this question? Should the therapist have posed the question at all? The analysis shows us that participants tend not to align on these issues when questions about what might be helpful are posed with minimally softened designs.

This finding regarding how simple *wh*-questions are associated with a *lack* of common ground between participants coheres with Thompson, Howes and McCabe's (2016) finding that psychiatrists' use of *wh*-questions predicted poor perceptions of the therapeutic relationship, showing significant links between apparently minor interactional details like question design and the quality of the relationship between mental health professionals and clients. The specific finding

regarding *wh*-questions seems to be because these questions do not propose as much, potentially empathic, understanding of the recipient's experience as other question forms might (e.g. declarative questions: "So you've been feeling sleep deprived the last few days?"). Such understanding might be conceptualized as an effort to build common ground between participants, which is lacking when *wh*-questions are posed with little or no accompanying material which might otherwise display some understanding and build the potential for alignment and affiliation.

In his analysis of therapists' responses to clients' story-tellings in therapy sessions, Muntigl (2016) also highlighted how the more empathy and fine-grained description of client experience therapists invested into their responses, the more affiliation they were likely to receive in response from clients. Muntigl found *wh*-questions were less suited for displaying empathy, although of course it might be possible for this effect to be mitigated if/when posed alongside accompanying material which does show understanding. Heritage (2011) also came to a similar conclusion regarding talk in everyday settings. Furthermore, Voutilainen, Peräkylä and Ruusuvuori (2010) found that therapists can use empathic interventions to build ground for more challenging actions such as interpretations. We can draw a link with the current findings in terms of the work that therapists invest in building common ground while also endeavouring to further their therapeutic agenda. In Sections 7.3 and 7.4, we will consider two further designs of questions about what might be helpful which show more work from the therapist in building common ground.

The particular context in which the therapist poses a minimally softened question may well compound this issue of a mismatch between expectations oriented to by participants. Take, for example, the context, discussed in Chapter Six, and present in Extracts HCYDT and BW in the current section, in which the client has just made an equivocal reference to a hoped-for state of affairs. Posing a question at this juncture involves de-prioritizing empathic, affective and affiliative relevancies and prioritizing a problem-solving framework. Some clients might experience this shift by the therapist as this point as a loss of empathic, impatience and, potentially, abandonment. Furthermore, posing a *question* which requires the client to come up with ideas themselves is face-threatening given that that the client's equivocal reference may also have functioned as an implicit

request. In such a context, posing the question as a minimally softened one may well be the move which temporarily stretched the common ground asunder.

In the current collection, clients treated minimally softened questions as problematic in other contexts as well (cf. Appendix D). However, a reasonable evaluation is that the contexts explored in Chapter Six are some of the more challenging ones in which therapists might pose a minimally softened question. Further evidence for this evaluation comes from Ribeiro et al.'s (2013b) finding, using the *Therapeutic Collaboration Coding System* (cf. Chapter Two), that when the therapist challenged the client after the client had just displayed ambivalence, the client tended to invalidate (i.e. reject or ignore) the therapist's intervention. The Ribeiro et al. study focused on client and therapist talk around understandings of the client's difficulties as opposed to meta- therapeutic talk about methods. However, it may well be that a similar process is occurring in contexts in which therapists pose relatively challenging, minimally softened questions after the client has just made an equivocal reference to a hoped-for state of affairs. As we have discussed, clients tend to misalign and disaffiliate in such contexts. Ribeiro et al. conceptualized these challenging interventions as working outside the client's *therapeutic zone of proximal development*. This seems an informative concept when interpreting the current analysis, alongside the notion that displaying understanding during a therapist intervention can contribute to common ground between client and therapist.

In summary, the findings in this Section 7.2 show how posing a question about what might be helpful, with minimally softened design – particularly after the client has displayed ambivalence may in fact display a lack of common ground between participants, such that the client responds by treating the question as problematic. So, what initially appears, from an interaction-far perspective, to be an apparent opportunity for meta-therapeutic dialogue can sometimes locally turn out not to be one which the client treats as feasible in the current circumstances. In the following sections, we will examine other possible means of designing these questions and how these can differently shape the opportunity for meta-therapeutic dialogue.

7.3 Substantially softened design

In this section, we will examine a case in which the therapist poses a question about what might be therapeutically helpful for which the response requirements have been *substantially softened*.

7.3.1 Illustration 1: Anything that can be done…such as…?

Extract ATCBD begins 25 minutes into the first post-assessment session. The therapist launches the question about what might be helpful from line 17 onwards: "↑So then do you think that uhm: (0.4) °.tch° (.)°umph° there:'s anything that can be done- (.) °umph° uhm: >in preparation... " The therapist poses the question here after the client has ended their prior turn with a pro-formulation (line 7, ".tch That kind of th#ing:"), making relevant a non-minimal turn-at-talk from the therapist. The therapist orients to this relevance by first producing an upshot formulation (lines 10-13) regarding the client's prior talk. The therapist then launches the question about what might be helpful from line 17.

Extract ATCBD *Session#1/Start25minutes/PairF*

```
 1  C:   ((continuing)) but she just sort of went >↓oh no: I think
 2       everything's fine, I think you're ↓overreacting: an[d, .hh]
 3  T:                                                      [R:ight]
 4  T:   Right.
 5       (.)
 6  T:   Mhm=
 7  C:   =.tch That kind of th#ing: hh
 8  T:   °Right°
 9       (1.0)
10  T:    °Yeah:° >so just feeling like< you wanted (.) to: help
11       a[nd: it] kinda (.)↓didn't re#ally g#o: the w#ay you w#ere
12  C:    [M:m   ]
13  T:   ex[pecting it.]
14  C:     [Ye::ah     ] >eh ↑h[uh<]
15  T:                          [Ye ]ah:
16  ?:   .hh hh
17  T:   ↑So then do you think that uhm: (0.4) °.tch° (.)°umph°
18       there:'s anything that can be done- (.) °umph° uhm: >in
19       preparation so you< don't become: so that the stress kinda
20       doesn't pile: up: in: a situation, such as Ben's
21       fam[ily coming] .hh that: maybe you can- (0.3) prepare for: or
```

22 C: [M:M]
23 T: kinda say things to Ben: .H maybe when they're there:, just:
24 to: kinda make sure that .hh you don't end up °umph-° with
25 this °eh-° massive amou[nt of stress] [(Ri-)]
26 C: [Ye:ah:] [I] think ↑if- I
27 th:ink, .HHh at the MO:ment, I'm just gonna have to be: (.)
28 not s:elfish, but what >>I would consider being selfish which
29 which<< [is] .HH if something happens and it really really
30 T: [M:hm]
31 C: starts to get to me, I'll just have to say: .hh (.) >I mean
32 on: th- the day they're: coming i:t's kind of lucky, in a
33 way:=I'm working in the eve:ning >'cause I can just say ↓ah
34 I've got to and: .hh
35 T: M:m=
36 C: =Get ready for wor:k, [or,] .hh you know, ehm:, (.) but I
37 T: [M:m]
38 C: think I'm- (0.4) DEFinitely: need: to >kind of< talk to B#en a
39 b#it [m#or:e] about it >'cause I think he ((continues))

The therapist prefaces the question about what might be helpful with "↑So then" (line 17), which depicts it as a relevant and pending action (Bolden, 2009). In lines 17-19, they then pose a yes-no interrogative regarding whether the client thinks "do you think that uhm: (0.4) °.tch° (.)°umph° there:'s anything that can be done- (.) °umph° uhm: >in preparation". Although this question is produced in the format of a declarative yes-no interrogative, a response of just 'yes' or 'no' from the client would be treated as insufficient i.e. it would not suffice for the client to just respond with 'yes' or 'no' after this question (Muntigl & Zabala, 2008; Schegloff, 2007). The therapist next delineates this initial interrogative with one aborted account (line 19: "so you< don't become:") and one completed account (lines 19-20: "so that the stress kinda doesn't pile: up: in: a situation, such as Ben's family coming") for asking this question. The therapist then continues past a point of possible turn completion at the end of this account to provide a suggestion for what the client might do (lines 21, 23: "that: maybe you can- (0.3) prepare for: or kinda say things to Ben: .H maybe when they're there:,") before ending the turn by re-iterating the earlier account for posing the question (lines 23-25: "just: to: kinda make sure that .hh you don't end up °umph-° with this °eh-° massive amou[nt of stress").

The question about what might be helpful is produced in a delayed and highly tentative manner. This tentative production is manifested in the multiple hesitations, perturbations, re-doings and accounts (e.g. lines 17-18). The multiple extensions to the question, including explanations and candidate suggestions, also contribute to this tentative production since they project a problematic response by the client if the therapist finished their turn after the initial question of ""do you think that uhm: (0.4) °.tch° (.)°umph° there:'s anything that can be done-". Such tentative production shows the therapist orienting to this question about what might be therapeutically helpful as a potentially problematic (Drew et al., 2013; Silverman & Peräkylä, 1990; Sutherland, Turner & Dienhart, 2013). Although the tentative production of question in Extract ATCBD projects that the client will treat it as problematic, it still also differs markedly from the *minimally softened* design, such that its design can be considered to *substantially soften* the response requirements facing the client. We will now examine how the therapist achieves this and how the client responds.

In Extract ATCBD, the therapist produces the question about what might be helpful in a noticeably more extended manner than in the minimally softened designs we examined in the last section. The initial yes-no question ("do you think that uhm: (0.4) °.tch° (.)°umph° there:'s anything that can be done-") would have made it relevant for the client to respond by independently producing their own ideas regarding what might be helpful. However, as we have seen, the therapist extends their turn by producing explanations (lines 19-20, 23-25) and suggestions (lines 21, 23). In contrast to the minimally softened design, these extensions to the therapist's question lessen the relevance of the client immediately and independently producing content about what might be helpful. This is because, firstly, these extensions render the question less contiguous with the start of the client's turn and thereby lessen the relevance of the client responding to the question at all (Sacks, 1987). Secondly, the therapist's production of the extensions takes up interactional time and space. In this way, the extensions also soften the response requirements by allowing for possible delays in the client responding (Hepburn & Potter, 2011b). In addition, the therapist uses a yes-no question format incorporating "anything". This format topicalizes the presupposition as to whether "there:'s anything that can be done" and favours a negative answer due to the use of the negative

polarity item “anything” (Boyd & Heritage, 2006; Heritage et al., 2007). As such, this question format favouring a negative or non-substantial response further softens the relevance of the client responding with their own ideas. Finally, the therapist provides suggestions which display an expectation that such scaffolding is necessary in order to render the question answerable by the client (Pomerantz, 1988; Huiskes, 2016). All of these features substantially soften the relevance of the client producing their own ideas in answering the question, since they are now only required to agree with the therapist’s suggestions or to provide a similar type of answer. This substantial softening is probably also a means of pursuing an answer of any kind from the client by making the question more readily answerable (Ekberg & LeCouteur, 2014a; Gale & Newfield, 1992).

There are also elements of the question design in Extract ATCBD which construct the agenda and the talk about what might be helpful as items which may not be immediately feasible to implement. For example, the therapist uses adverbs, such as “kinda” (line 23) and “maybe” (line 21) to mitigate or downgrade the epistemic certainty associated with their candidate suggestions (Ekberg & LeCouteur, 2014a). In addition, the therapist uses an indirect, agent-less format for the question, “anything that can be done-”, which distances the client from helpful actions that might need to be taken. This distancing helps to frame a slightly more hypothetical discussion of what might be helpful, rather than one which prioritizes immediately feasible or implementable actions. This mitigation of a focus on producing ideas or suggestions which are immediately feasible also contributes to softening the response requirements, since the client does not have to be fully committed to any ideas that they volunteer.

With the *substantially softened* question design, the therapist employs a selection of design features that soften the relevancies of the client immediately and independently responding with feasible ideas. The *substantially softened* design softens or reduces these relevancies but it does not entirely do away with the interactional constraints associated with genuine questions. As a *telling question* (Fox & Thompson, 2010), a *substantially softened* question about what might be helpful still makes relevant a non-minimal response from the client. Furthermore, these practices to soften the response requirements also work to pursue an aligning answer from the client (Strong &

Sutherland, 2007). For example, the practice of providing suggestions also pre-empts a possible not-knowing response by the client. The client is now only required to confirm the therapist's suggestion or to provide a similar type of answer (Ekberg & LeCouteur, 2014a). This relevancy makes it more difficult for the client to produce a not-knowing response and in this sense pursues an aligning response from the client.

7.3.1.1 Client's response The client does not treat the question about what might be helpful as problematic. Indeed, the client overlaps with the therapist's elaboration of the question to launch a substantial answer (line 26). They begin by introducing new content regarding what might be helpful via the category of being "selfish" (lines 26-29). Aside from this new category, much of the rest of the content of the client's answer falls within the parameters set up by the therapist's explanations and suggestions. For example, in line 31, framing their answer in terms of having "to say:" something to Ben's family, which is similar to the therapist's suggestion in line 23 and the same in line 38 with the client's reference to needing to "talk to B#en".

In summary, in Extract ATCBD, there is a clear and expectant conversational floor for the therapist to launch a new interactional sequence or activity. The therapist uses this opportunity to produce a question about what might be therapeutically helpful. The therapist's halting production and multiple extensions to the question show how they are treating the question as potentially problematic. However, in contrast to the *minimally softened* design, the therapist's question in Extract ATCBD *substantially softens* the response requirements for the client to either immediately and independently produce content about what might be helpful or else produce an explanation for not doing so. The therapist accomplishes this *substantial softening* by constructing an unpresuming stance as to whether the client can answer and in providing scaffolding in the form of explanations and suggestions so that the question becomes more readily answerable for the client. In eliminating the relatively more demanding requirements for the client to have to immediately and independently produce content, this scaffolding may also work to pursue more than a not-knowing answer from the client. The client responds immediately by answering the question and thus treats

the question about what might be helpful as unproblematic in this context. However, most of the content of their answer falls within the parameters set up in therapist's question.

7.3.2 Illustration 2: Anything else that would make things easier…or?

Extract AEYTMTE contains another example of a therapist producing a question about what might be helpful with a substantially softened design. This occurs 24 minutes into the second post-assessment session. The therapist poses the question in lines 10-12: ">is there anything else< you think .hh that maybe would- m:ake things easier?=for you, °so you don't get so stressed ou:t? #Or?°"

Extract AEYTME *Session#3/Start23minutes/PairF*

```
 1  C:   ((continuing)) stay ↑here th#en.
 2  T:   .Hh So kinda things like, (0.3) vi- n:ot always thinki:ng that
 3       he's right kinda being able to (.) to listen to: y- your side
 4       of things a bit mo[re, .hh] and maybe
 5  C:                     [M:m.  ]
 6  T:   >kinda something about him< taking initiative more? [A:nd, ]
 7  C:                                                      [Ye:ah.]
 8  T:   yea:h .hh ye:#ah.
 9       (.)
10  T:   Mw- >is there anything else< you think .hh that maybe would-
11       m:ake things easier?=for you, °so you don't get so stressed
12       ou:t? #Or?°
13       (0.9)
14  C:   .pch (0.3) >↑I don't know.< I th↑ink (.) tha:t (.) it's (0.4)
15       it's: kinda of hhh (0.4) .tch (0.8) I ↑just th↑ink there's
16       #ah- >I think he thi-< (.) >being completely honest I think he
17       just needs to< (.) <gro:w up> a little [bit?]
18  T:                                          [Mm. ]
```

In Extract AEYTMTE, the question about what might be helpful forms part of a shift by the therapist to re-focus on the topic of what might be therapeutically helpful, which they had previously introduced (not shown in current extract). As part of this re-focusing shift, the therapist produces an upshot formulation (lines 2-4, 6, 8) which summarily glosses the client's prior troubles-telling and complaining talk about their partner (e.g. line 1) in terms of what the client could helpfully discuss with their partner, for example, "him taking the initiative more" (line 6). After the client minimally

confirms this formulation in line 7, the therapist asks our question of interest in lines 10-12, which explicitly re-focuses the talk on “anything else that would make things easier”.

The therapist in Extract AEYTMTE invests substantial work to shift from the client’s complaint about their partner by summarizing their prior turn as talk about what might be helpful and then by posing the question about what might be helpful. The client has a role to play in making this shift succeed by aligning with it. They have done so in line 7 and they refrain from taking a turn in the pause in line 9, which creates a clear opportunity for the therapist to continue to develop their agenda.

Similarly to Extract ATCBD, the therapist’s design of the question about what might be helpful is halting and perturbed. For example, the therapist begins their turn in line 10, with a turn-initial vocalisation “Mw-”, an in-breath “you think .hh that maybe”, a cut-off “would-”, and an elongation “m:ake”. This delayed and perturbed treatment projects a problematic response from the client (Drew, Walker & Ogden, 2013). However, also similarly to Extract ATCBD, alongside this projection of a problematic response, the therapist produces some features which soften the response requirements for the client even more substantially. For example, the therapist utilizes a yes-no interrogative in which the possibility that the client will not be able to answer is referenced in the question phrase “Is there”. A further indication of this possibility occurs with the use of “anything else”, which promotes a negative answer from the client (Boyd & Heritage, 2006; Heritage et al., 2007). This lack of presupposition within the question design that the client will be able to answer further contributes to softening the response requirements. This is since the client would need to do less interactional work to decline to answer because the question design itself holds open the possibility that the client might decline. The response requirements are also softened by the hypothetical focus of the question (line 10: “would”) and the use of “maybe”, further mitigating the relevance of the client producing an immediately feasible suggestion or idea.

Another means by which the therapist substantially softens the response requirements is to continue their conversational turn after a possible point of completion of the question (Huiskes, 2016). The therapist could have instead ended their turn after producing “make things easier for

you" in line 11, since this would have brought the question to a point of grammatical, prosodic and pragmatic completion. However in continuing on, the therapist orients to the possibility that they have not yet posed the question about what might be helpful in a form that is unproblematically answerable for the client (Raymond & Heritage, 2013). Furthermore, in producing material after this point, the therapist is providing the client with additional time and space before they have to respond to the question.

In continuing beyond the point of possible completion, the therapist produces an account or rationale, "so you don't get stressed out" (lines 11-12), for asking this question about making things easier. Similarly to Extract ATCBD, as well displaying some accountability by the therapist for posing the question about what might be helpful (Peräkylä, 1998; Parry, 2009), it also constitutes scaffolding regarding possible answers. That is, it displays to the client that they should respond by enumerating "things that would make things easier" so that they would not "get so stressed out". This scaffolding softens the response requirements since the client is not left to independently give ideas after "for you" in line 11. This scaffolding also makes it more difficult for the client to respond by taking up a not-knowing position. As such, again similarly to Extract ATCBD, we can conclude that the therapist's addition of post-interrogative material works to pursue an answer from the client since it lessens the ground for the client to respond by treating the question as problematic or as difficult to answer (Ekberg & LeCouteur, 2014a).

The therapist's addition of a turn-final "or" comprises a continuation past a second point of possible completion in producing this question. This addition of a turn-final "or" is a somewhat ambiguous practice (Drake, 2015). It may be heard either as an implicit acknowledgement that there may not be "anything else" that "would make things easier" or as the implicit proposal that there may be other possible delineations of the scope of the question about what might be helpful (i.e. apart from the therapist's summary of helpful actions in lines 2-4 and 6). In the case of the former hearing, the turn-final "or" would then further project that the client may not be able to supply an answer to the question about what might be helpful. In the case of the latter hearing, it would work to delineate a low threshold of specificity regarding what counts as an appropriate answer. This

would then re-open the field of possible responses after the more specific delineation produced just previously i.e. “so you don’t get so stressed out”. In the case of this latter hearing, the overall question design could then be seen to have multiple, apparently opposing functions, in terms of more specifically delineating the scope of the question to render it more readily answerable by the client, while still also displaying that it would be possible and acceptable for the client to provide an answer which extended beyond this delineation. Given the ambiguity concerning possible hearings of the turn-final “or”, both of these hearings may be treated as relevant by the client.

Thus, the design of the question about what might be helpful in Extract AEYTME is encompasses a few multifaceted practices, which substantially soften the response requirements while also performing other functions, such as pursuit and de-specifying work. For example, similarly to Extract ATCBD, in continuing beyond the first point of possible completion to produce scaffolding and in producing an unpresuming question form, the therapist works to render the question about what might be helpful readily answerable by the client so that it cannot be countered by a not-knowing or otherwise misaligning response. However, in thus softening the response requirements, these practices can also be seen to simultaneously *pursue* an unproblematic answer from the client. The therapist’s addition of a turn-final “or” further complicates the design by ambiguously highlighting either the unpresuming nature of the question or by re-opening the field of appropriate responses to extend beyond the scaffolding. This design creates a question about what might be helpful which works to be unpresuming, while still pursuing a response by rendering it more readily answerable, while still also apparently working to highlight a low threshold of specificity for responses.

7.3.2.1 Client’s response After the therapist’s turn-final “or”, there is a (0.9) pause in line 13 before the client starts to verbally respond to the question about what might be helpful. Both this pause and the further turn-initial delays “.pch (0.3)” in line 14 project a dispreferred response, which is fulfilled by the client’s subsequent “I don’t know” preface (Keevalik, 2011; Beach & Metzger, 1997) and further displays of perturbations and difficulty in responding to the question (lines 14-16: “I

th↑ink (.) tha:t (.) it's (0.4) it's: kinda of hhh (0.4) .tch (0.8) I ↑just th↑ink there's #ah- >I think he thi-< ”). The client then goes on to develop a complaint about a third party through negative assessments of their partner's behaviour (e.g. lines 16-17). This complaint topically fits as a response to the therapist's question regarding “might make things easier”. However, the just-prior highly perturbed talk suggests the client is orienting to something problematic in producing this complaint in answer to the question about what might be helpful.

To summarize, the client responds with a display of difficulty, an initial claim of lack of knowledge and eventually a third-party complaint. This complaint starts a shift by the client away from the question focus on what might make things easier and back to an extended complaint about their partner. (The rest of this complaint is not shown in this extract). However, the client's display of immense difficulty in developing this complaint shows that they are not fully aligning with either hearing of the therapist's the turn-final “or”.

In Extract AEYTMTE, the therapist poses a question about what might be helpful in a context where the client has so far minimally aligned with the therapist's efforts to re-focus the talk. As with all of the cases we have examined so far, the therapist's design of the question about what might be helpful incorporates features which project a problematic response from the client. The therapist also employs a *substantially softened* design for this question by not presuming whether the client is able to answer, while simultaneously pursuing an answer by providing scaffolding. The turn-final “or” creates some ambiguity as to whether the therapist is highlighting the possibility that the client might disconfirm the possibility that there is “anything else” that might be helpful or whether the therapist is highlighting a low threshold of specificity for how the client might answer. The client responds with a highly perturbed display of difficulty and eventually shifts back to a complaint-telling and thereby discontinuing the focus on talking about what might be helpful.

7.3.3 Clinically-focused discussion

We have now examined two instances of therapists employing a *substantially softened* design when asking the client about what might be helpful. We have seen how this design reduces the

requirements for clients to immediately and independently produce feasible ideas or content. This *substantially softened* design addresses some of the difficulties arising with the *minimally softened* question design, since ground is prepared for the question and thereby lessens the grounds available to the client to say they do not know. In thus softening the response requirements of the question, this design also works as a pre-emptive, same-turn pursuit of an aligning and substantial answer from the client (Clark & Hudak, 2011; Ekberg & LeCouteur, 2014a; Strong, Pyle & Sutherland, 2009). This *substantially softened* design is therefore one means by which therapists can implement Cooper et al.'s (2016) recommendation to ask questions about what might be helpful, while also managing the local interactional possibility that the client may not be able to answer.

An essential difference between the minimally and substantially softened designs concerns the amount of ground preparation work invested by the therapist. For the minimally softened design, the therapist tends to pose the question with the shortest of preludes. In contrast, for the substantially softened design, the therapist invests plenty of groundwork in explaining the rationale for posing the question and in giving suggestions which scaffold or model potential answers. In investing this work, therapists can be seen to pre-empt or mitigate problems which might cause clients to resist the question as they would for a minimally softened design. As discussed in Section 7.2, such problems might include a loss of face for the client in having to immediately give their own ideas after having made an implicit request or a mismatch between participants' orientations to their respective roles and responsibilities for knowing about what might be helpful. As such, the substantially softened design shows therapists attending to the relational implications of posing a question which attempts to introduce a problem-solving framework (Strong, Pyle & Sutherland, 2009).

The findings in this section regarding the this *substantially softened* design also illustrate differences in how the clients respond even though the therapist in both Extracts ATCBD and AEYTME employs a *substantially softened* design. In Extract ATCBD, the client responds with a substantial answer which treats the question about what might be helpful as an unproblematic and straightforward action, whereas in Extract AEYTME, the client responds with a display of difficulty, a

complaint about a third party with a concomitant shift away from the topic of what might be helpful. Given these different responses to two questions about what might be helpful with similarly *substantially softened* designs, we can conclude that how the therapist designs the question about what might be helpful is relevant but not sufficient for securing an aligning and substantial answer from the client. Another contributing factor is whether or not the client and therapist are aligned regarding the question agenda at this particular point in the interaction. However, the point still holds that in the current sample, even if clients do not fully align with the question agenda, they still tend to respond less dis-affiliatively to *substantially softened* questions. This follows the general tone of Muntigl's (2016) finding that the more displays of understanding and affiliative work therapists invested in their responses, the more affiliation they received back from clients. It also coheres with Voutilainen, Peräkylä and Ruusuvuori's (2010) finding that empathy can prepare the ground for more challenging interventions, such as the cases of questions about what might be helpful currently under discussion.

A final consideration arising from these findings regarding *substantially softened* designs concerns the nature and limits of the kind of answer they make relevant from the client. In working to make the question more answerable by the client, the therapist may also reduce the scope of the opportunity for the client to introduce new content regarding what might be helpful. For example, although the client in Extract ATCBD produced a straightforward answer, this can be seen to lie predominantly within the parameters of the therapist's question about what might be helpful. This highlights the possibility that some question about what might be helpful may function more as vehicles for promoting acceptance of therapist's scaffolding or suggestions to the client, that is, as opposed to opportunities for the client to introduce new content (cf. also Chapter Five). A speaker's production of suggestions implies their endorsement of the content (Butler et al., 2010). It is then relevant for the recipient to respond to this endorsement, for example, by resisting or by agreeing. Additionally, if the therapist's suggestions are contiguous with the start of the client's response, then this increases the relevance of the client responding to the suggestions and thereby detracts from the relevance of the client introducing new content. Therapists should be aware of these

relevancies created by suggestions at the end of their conversational turn and how they de-emphasize the relevance of clients answering with their own suggestions.

Thus a dilemma arises for therapists when posing questions about what might be helpful: If they pose a question with this *substantially softened* design, they risk reducing the relevance of the client producing new ideas. However, if they pose a question with a minimally softened design, they risk that the client will treat response requirements as problematic. Neither design by itself seems likely to fulfil the pluralistic therapy mandate for therapists to create genuine opportunities for clients to introduce their own ideas regarding what might be therapeutically helpful.

In the face of this dilemma, the therapist's addition of a turn-final "or" in Extract AEYTME offers a glimpse of a possible third option or route out of this apparent interactional dilemma. As previously observed, the turn-final "or" is ambiguous and either highlights the possibility that the client might disconfirm the relevance of the question about what might be helpful or else it highlights a low threshold of specificity for answers. The latter hearing shows how the therapist could potentially open up or *de-specify* the field of possible answers beyond any scaffolding they have previously produced. This represents another solution to the dilemma outlined above, whereby the therapist provides scaffolding to the client before, finally, at the end of their turn, re-opening up the field to emphasize the relevance of the client introduce their own ideas. However, in Extract AEYTME the possible third option of this *de-specifying* practice is somewhat obscured by the ambiguity in how the turn-final "or" can be heard. If present at all, the *de-specifying* practice here is highly implicit. This observation raises the question as to if, and if so then how, therapists might achieve a more explicit *de-specifying* question about what might be helpful. We will now move on to examine some such cases.

7.4 Softened & de-specifying design

In this section, we will examine cases in which the therapist poses a question about what might be helpful for which the response requirements are *softened*. Then, within the same conversational

turn, the therapist *de-specifies* or opens the field of possible answers, thus inviting the client to answer with their own ideas.

7.4.1 Illustration 1: If you could chose a therapy or something…

In Extract AI, the therapist from Pair A poses a question about what might be helpful 55 minutes into the assessment session: " uhm have you got any i:dea … do you have any i:dea abou#t, .h if there was a therapy, if you could choose a therapy or something." (lines 10-16). In posing this question, the therapist shifts away from the client's recent talk about what might be helpful regarding a specific difficulty (e.g. lines 1-2). The therapist executes this shift in lines 7-8 with a pre-question about whether the client has had counselling before: ".hh °eh-° (.) tell ↑me (.) Mary, >>have you<< ↑↑had any previous therapy?" There is evidence that this topic shift by the therapist is somewhat interactionally risky. For example, the client treats the pre-question as somewhat abrupt or problematic, since they do not immediately respond (i.e. line 9) and the therapist then apologizes for how they posed the question (line 10: "Sorry to come across you there").

Extract AI *Session#0/Start54minutes/PairA*

```
 1  C:   ((continuing)) so what- (0.4) I've dHhone with that is that I try
 2       and have as le:ss contact with my mum, (0.5) as possible.
 3       (.)
 4  T:   °Oki dokey.°
 5       (0.5)
 6  C:   Ehm:,
 7  T:   .hh °eh-° (.) tell ↑me (.) Mary, >>have you<< ↑↑had any
 8       previous therapy?
 9       (.)
10  T:   Sorry to com[e ac]ross you there. [No? ] .hh uhm have you got
11  C:                [No. ]                [°No°]
12  T:   any i:dea >>but I think that we- you said you had a friend
13       who's a#: th[erapi]st, .hh do you have any i:dea abou#t, .h if
14  C:                [Mm.  ]
15  T:   there was a therapy, if you could choose a therapy
16       [or something.]
17  C:   [.hhh          ] I th:↑ink
18  T:   °Anything in mind° [( )  ] you want to (g[ive me)]
```

19 C: [That-] [(the-)]
20 (.)
21 C: S: psychotherapy and then the one:, that (.) the- the family:
22 (0.3) thing.
23 (.)
24 T: [Yeah.]
25 C: [Because] I think it's something that we all do in our f-
26 >like my brother and sis:- we've all .hh (0.5) gone through
27 little stages of it. >I think we've all got bits of .hh
28 because like: if you speak to outside people >they say yeah
29 because you ((continues))

Focusing now on the design of the question about what might be helpful, the therapist initially poses a yes-no question (lines 10, 12: 'uhm have you got any i:dea...'), before arresting this questioning action to contrastively refer to an earlier discussion they have had in the same session on a similar topic (lines 12-13: ">>but I think that we- you said you had a friend who's a#: therapist,"). The therapist then restarts the question using another yes-no question (line 13: "hh do you have any i:dea abou#t,") which enquires whether the client has a preference for a particular type of therapy. In line 17, the client starts to respond in overlap with the therapist's extension of the question ("or something."). However, the therapist briefly retakes the conversational floor in order to reiterate their request that the client supply some suggestions (line 18: "°Anything in mind° ( ) you want to (give me)").

In launching the question about what might be helpful in Extract AI, the therapist employs features which soften the response requirements placed on the client. These features are similar to those we examined during the substantially softened design in the last section. I will firstly illustrate these features before considering some *de-specifying* aspects.

The therapist's development of the question about what might be helpful here incorporates interruptions, re-doings and a question extension (i.e. "or something" in line 16). This interactional work by the therapist takes time, and so, delays the point at which a response from the client becomes relevant. This delay softens the response requirements since it provides a buffer from what would otherwise be immediate pressure to respond. Another practice softening the response

requirements stems from the therapist's posing of two yes-no interrogatives. This question form topicalizes the possibilities that the client may or may not have "any idea" regarding an appropriate response to the question and thus does not presuppose that the client already has an "idea". Additionally, the use of the negative polarity item "any" facilitates the client to respond negatively and non-substantially (Heritage et al., 2007; Boyd & Heritage, 2006). This negative tilting constructs the question about what might be helpful as less of an obligation and more of an invitation, depending on whether the client is able to do so or not.

The therapist also softens the response requirements by providing scaffolding to the client regarding what kind of talk can be supplied as an answer. For example, in lines 12-13, the therapist interrupts their launching of a question ("have you got any idea") to contrastively refer to an earlier discussion they have had in the same session on a similar topic ("but I think that we- you said you had a friend who's a therapist").This reference to previous talk in the session demonstrates how one relevant answer to the question would be to build on some of this previous talk. The response requirements are softened by this scaffolding since the client is no longer has to independently produce new content in answering. In addition, as we have noted for cases of the substantially softened design, the therapist's scaffolding has a somewhat less obvious interactional flipside, in also functioning as a same-turn pursuit of an answer. This is because the provision of scaffolding detracts grounds from the client for constructing a not-knowing response (Ekberg & LeCouteur, 2014a).

Moving on to the *de-specifying* aspects of the design, the therapist forms the question using low modality or hypothetical constructions, for example, "if there was a therapy, if you could choose a therapy" (lines 13, 15). These hypothetical constructions lower the threshold for acceptable answers since they do not render the client accountable for following through on any suggestions they make (Ekberg & LeCouteur, 2014a; MacMartin, 2008). Furthermore, towards the end of the question, the therapist produces the question increment "or something" (line 16), which emphasizes a low threshold of specificity or a broad topical agenda (Clayman & Heritage, 2002) for how the client could answer. The therapist reiterates this low threshold of specificity for appropriate

responses by temporarily re-taking the conversational floor in line 18 – despite the client having started to respond – in order to produce another increment "anything in mind you want to give me". This further opens up and de-specifies the field of possible answers by explicitly inviting and encouraging whatever ideas the client might choose to give.

This *de-specifying* aspect of the question design also works to elicit a response from the client. For example, the use of hypothetical constructions makes it more difficult for the client to develop grounds for resisting the agenda of their giving ideas about what might be helpful. The phrases specifically emphasizing a low threshold ("or something"; "anything in mind you want to give me") also work to elicit an answer from the client. In particular, the negative polarity item "anything" here can be seen to do some pursuing work since it emphasizes a wide-open invitation for the client to volunteer ideas (Ekberg & LeCouteur, 2014a) or even for the client to just "have a go" (Houen et al., 2016, p.74). This pursuing work implemented by "anything you want to give me" is further evidenced here by its post-turn position as an increment, frequently a position from which answer pursuits are launched (Pomerantz, 1984a). Indeed, this increment "anything you want to give me" serves to illustrate the fine line the therapist is treading in the design of this question about what might be helpful. On the one hand, with this increment, the therapist emphatically invites the client to answer with their own ideas, while on the other hand, the use of negative polarity item "anything" constitutes an implicit acknowledgment that the client may not any ideas. In this way, the therapist finds a balance between softening response requirements while still also encouraging and pursuing new content from the client.

To summarize, the therapist in Extract AI uses several practices to soften the relevance of the client to immediately and independently producing feasible ideas. In addition, the therapist de-specifies the field of possible answers by endorsing the client's discretion in terms of what might be considered an appropriate answer. These softening and de-specifying practices also have a pursuing side since they make it more difficult for the client to produce a not-knowing response.

7.4.1.1 Client's response

As noted earlier, the client starts to answer in line 17, but therapist overlaps to reiterate the low threshold of specificity for answers. The fact that client tries to answer at that stage, shows them treating the question as an action to which it is straightforward for them to respond. In lines 19 and 21-22, the client answers by selecting or endorsing types of therapy which the client and therapist talked about earlier in the session. The therapist also referred to this talk in their scaffolding which formed part of the question about what might be helpful. Evidence that the client's answer is building on this earlier talk includes their use of "the" to refer to a previously-established reference i.e. "(the-)(.) S: psychotherapy and then the one:, that (.) the- the family: (0.3) thing" (lines 19, 21-22). As such, the client here has taken up the scaffolding provided by the therapist regarding a possible answer to the question about what might be helpful. The client then follows up this endorsement or selection with an extended account in lines 25-29. In doing so, the client here is treating the content of their answer as an accountable matter.

In Extract AI, the therapist executes a topic shift to provide for the relevance of asking a question about what might be helpful. The softened and de-specifying design is particularly striking in terms of how the therapist moves between a range of different stances regarding how the client might answer. Firstly, they work to show they are not presuming the client can answer while also providing scaffolding which signposts the client to specific material for answering before finally emphasizing a low threshold of specificity to open up the field of possible answers. The client treats the question about what might be helpful as unproblematic to respond to and answers by taking up the scaffolding provided by the therapist. The client then proceeds to treat the content of their answer as a matter for which they need to account.

7.4.2 Illustration 2: I've been throwing..ideas..but how would you like?

Extract HWYL starts 25 minutes into the fourth post-assessment session between Pair A. The therapist poses a question about what might be therapeutically helpful in lines 17-18: "So what do you think. I've been throwing these ideas at you, bu (wha-) how would you like a a session to go:".

The therapist poses this question at the end of their extended holding of the conversational floor (lines 1-15), in which they make suggestions about how it might be helpful to spend future sessions (lines 1-3, 5-6, 9-10, 12-15), such as ">And maybe until that's: (.) you feel like you've done enough on that?" (lines 5-6). The client minimally agrees at various points, but does not otherwise respond, which is partially due to the lack of opportunity while the therapist holds the floor. In posing the question in lines 17-18, the therapist explicitly works to address this recent lack of opportunity for the client to substantially participate in talking about what might be helpful.

Extract HYWL *Session#4/Start47minutes/PairA*

```
 1  T:   ((continues)) .hh so we ca- we can also make sur#e=at the end of
 2       the sessions, th#at we've got time to have a look through: .hh
 3       like the genogram. Work as well.
 4  C:    yeah.
 5  T:   >And maybe until that's: (.) you feel like you've done enough
 6       on that?
 7       (.)
 8  C:   Ye:[ah]
 9  T:      [S:]o: uhm: if that's something we wanna get in as well, I
10       can keep an eye on the time:, .hh
11  C:   yeah.
12  T:   Uhm and: we can make sure that we: uhm: spend s- fifteen
13       Minutes? Or someth[ing? Or >t]wenty minu[tes (or that)] before
14  C:                     [yeah.     ]          [Yeah.       ]
15  T:   we get to the end?=Does that ↑soun[d (alright).] .h[hh   s]o:
16  C:                                     [Yeah.       ]   [°yeah°]
17  T:   So what do you think. I've been throwing these ideas at you,
18       bu- [(wha-)] how would you like a a session to g[o:.]
19  C:       [Yeah. ]                                   [.hh]
20  C:   ↑Ehm
21  T:   >>What would you like me to do more of or less of:.
22  C:   ↑I- (0.3) I- jh ↑realized like (0.3) uhm (0.5) I- t- I kinda
23       felt that ↓we'd- it's really funny because we kinda uhm: (1.3)
24       BOUnce off each other, so .hh as I'm thinking something then
25       you bring it up and I did think- .hh I £said to e:hm (0.5)
26       .shih my friend that (.) asked me ↑how are you getting on
27       s#ort of thing, and I said to h#er: at work, and I said to
28       her, I think I'm moaning too much and it's not getting me
29       anywhere, because [.hh] the- like- it's not I don't need to
```

30 T: [M:m]
31 C: moan .h because it's all about (.) the same thing. so I said
32 to her °this week I'm gonna talk less° but you've alREAdy
33 brought it (0.3) up. .hh because I'd- I'd- what I wanna know:
34 ((continues))

In posing the question about what might be helpful, the therapist issues a view-elicitor with an open field of response "So what do you think" (line 17). They then immediately explain why they are trying to elicit the client's views by describing the foregoing suggestions as "ideas" which they have been "throwing" at the client (line 17). They then pose the question about what might be helpful to the client, "bu (wha-) how would you like a a session to go:" (line 18). In line 20, the client starts to respond ("↑Ehm") but in line 21 the therapist quickly re-takes the conversational floor to pose another question ">>What would you like me to do more of or less of:". This is a more specific, alternative version of the question posed in line 18.

As we have seen, the therapist initially poses a *wh*-question about what might be helpful: "how would you like a a session to go:" (line 18). This is a relatively presuming and immediately demanding question format, but the therapist incorporates several features which soften these response requirements. First, the close vicinity of the therapist's previous suggestions about what might be helpful (i.e. lines 1-15) provide some scaffolding regarding possible answers. Second, in providing an explanation and thus showing some accountability for posing the question, the therapist does not fully presume that this is a question that the client should be able to answer (Peräkylä, 1998; Parry, 2009). Third, the therapist works to make the question more readily answerable by the client by posing an alternative, more specific version in line 21: ">>What would you like me to do more of or less of:" Fourth, this alternative version also functions as post-interrogative material, lessening the relevance of the client having to immediately respond. That the therapist overlaps to produce this alternative version even when the client has made a move to respond in line 20 shows them attaching high importance to producing post-interrogative material to mitigate any problems the client might have in answering.

Alongside this softening of the response requirements, the therapist's question about what might be helpful also contains some other features which work to de-specify or open up the field of possible answers. The strongest de-specifying element lies in how the therapist produces two wh-questions. These maintain the relevance of the client responding by independently producing their own ideas rather than responding to material that might otherwise be produced by the therapist. Maintaining this relevance is a de-specifying action since it clears or resets the field of possible responses after the therapist's previous suggestions. Furthermore, the therapist's explanation for posing the question explicitly distinguishes between the therapist's previous suggestions and the client's own ideas about what might be helpful. The therapist's use of an unfavourable term, "throwing ideas", to gloss their previous suggestions also casts the question about the client's own ideas as a desirable alternative. Both this explicit distinction and the favourable presentation of the client's own ideas work to differentiate the field of possible answers from the therapist's previous suggestions. This amounts to a re-opening up of the relevancies of how the client might answer the question, the de-specifying elements making it more relevant for the client to produce their own ideas on what might be helpful.

In sum, the question about what might be helpful here in Extract HWYL shares most of the same features of *softened and de-specifying* design as Extract AI. The therapist providing scaffolding and pursues by making the question more readily answerable, while still also explicitly emphasizing a low threshold of specificity for answers. Furthermore, similarly to Extract AI, the view-eliciting questions are contiguous with the client's response, which renders them more relevant for the client to respond to than the preceding scaffolding. However, the presence of this scaffolding and the other preparatory work done by the therapist means that the response requirements facing the client are still substantially *softened* compared to those for the *minimally softened* design.

7.4.2.1 Client's response The client immediately responds by providing a substantial answer thereby treating the question as unproblematic. For example, from line 32, the client introduces new content regarding their experience of the session, with some indirect indications of how they

think it could be more helpful: "so I said to her °this week I'm gonna talk less° but you've alREAdy brought it (0.3) up. .hh because …what I wanna know: …is … " (lines 31-32). Thus, the client here provides their own ideas in the form of feedback to the therapist. Notably, the client's answer also contains multiple perturbations (e.g. line 22: "↑I- (0.3) I- jh ↑realized like (0.3) uhm (0.5) I- t- I kinda") and indirect formulations (e.g. line 27-28-: "and I said to her, I think I'm moaning too much"). Furthermore, the client produces an explanation for the content of their answer (lines 28-29, 331): "it's not getting me anywhere, because…I don't need to moan because..."). This perturbed and indirect production of their answer and the work the client does to explain why they are producing it all evidence how the client is treating their answer as a highly delicate matter.

In Extract HWYL, the therapist poses a *softened and de-specifying* question to explicitly address a recent lack of opportunity for the client to substantially participate in talking about what might be helpful. The therapist's just-prior suggestions provide scaffolding to the client, whilst also producing two simple *wh*-questions as the items most contiguous with the client's turn. This positioning renders these questions most relevant for the client to substantially respond to. In responding, the client produces a highly dispreferred, but still aligned and on-topic answer. In doing so, they provide new content in the form of feedback to the therapist, and thus, an answer drawing on their own ideas of what might be therapeutically helpful.

7.4.3 Clinically-focused discussion

With the *softened and de-specifying* design, the therapist achieves the best of both worlds: They are not presuming the client can respond and therefore provide scaffolding, while still also ending the question by opening up the field of possible responses and thus creating an opportunity for the client to contribute their own ideas. The therapist therefore creates an open field for the client to answer with their own ideas, which is somewhat akin to that opened up by minimally softened questions. However, the less direct, softened route through which the therapist first provides scaffolding before then re-opening the field means that they avoid client's treatment of these questions as problematic, for example, due to the epistemic and face issues previously discussed.

The ordering of the softening and de-specifying elements is important here, since the softening must happen first as ground preparation and the de-specifying elements needs to be close to or contiguous with the start of the client's turn so that there is clear relevance created for the client to respond with their own ideas.

This softened and de-specifying design is therefore one means therapists can use to overcome the practical dilemma, of facilitating clients to contribute their own ideas about what might be helpful, while minimizing the possibility of misalignment. In short, with the softened and de-specifying design, the therapist models an answer, whilst also presenting it as not *the* answer. This design shows the therapist investing substantial work in ground preparation, which positions the therapist as the knowledgeable expert guiding the client. However, alongside this expert-led, preparatory work, the therapist then creates a clear opportunity for the client to contribute with their own ideas, thereby positioning the client as also being potentially knowledgeable about what might be helpful. Here we see the therapist's movement between different constructions of the client as being both less and more knowledgeable, which works to facilitate the client to answer with their own ideas while also first pre-empting any problems pertaining to incongruencies in treatment of epistemic roles and responsibilities or around the question being treated as potentially face-threatening or challenging. This movement between different epistemic constructions of the client and of the relative roles and responsibilities of the therapist and client illustrates one possible means of overcoming the paradox mentioned in Chapter Six pertaining to how the therapist might expertly shift towards creating an opportunity for meta-therapeutic dialogue, while still also working to make this opportunity as mutual and as egalitarian as possible, given the reality of their roles as client and therapist, service-user and professional, inexpert and expert member and so on.

A further implication of this finding is that the softened and de-specifying design may constitute a more genuinely viable and facilitative opportunity for the client to contribute *their own ideas*, than either of the two designs we have examined previously. Of course, other ways of designing questions about what might be helpful can still be therapeutically useful or meaningful, even if they do not facilitate an immediately viable opportunity for the client to give their own ideas.

For example, these questions might contribute to normalizing a culture of talking about what might be helpful (McLeod, 2013). Also highly relevant to the therapeutic meaning of each question about what might be helpful is how clients and therapists treat its aftermath and the clients' initial response – whether this response is an aligning or a misaligning one. We will explore participants' management of this aftermath in Chapter Eight.

As we have seen, when answering the *softened and de-specifying* question about what might be helpful, clients still orient to their answers as something for which they are accountable, that is, as something they should be able to explain. This shows that, regardless of whether therapists might soften the question design, clients treat themselves as accountable for their answer. Clients may treat themselves as accountable since their production of a substantial evaluative answer positions them as knowledgeable (Keevalik, 2011). This accountability that comes with answering a question may therefore be one reason that clients are reluctant to immediately answer questions. For example, if, under some possible constructions of the client role, if a client shows that know what might be helpful, then maybe this equates to them not needing as much as some others? There might be a link here between taking up an inexpert client role and showing that one has issues which are *doctorable* (Heritage & Robinson, 2006) or which need to be treated by a professional. Furthermore, when clients do given ideas, then they become accountable, in the interaction, for explaining and justifying these ideas. As noted by Solberg (2011), this accountability can become all the more important to avoid, if the client feels that their ideas need to be immediately feasible or if the introduction of their own ideas will directly implicate them in a change or adjustment to the therapeutic approach. Some implications for practice stemming from this observation will be discussed in Section 7.6.1.

7.5 Frequency of designs across cases

Table 7.1: Frequency of three designs of questions about what might be helpful

Pair	Therapist	Level of Experience	Question design			Total
			minimally softened	substantially softened	softened and de-specifying	
A	1	Trainee	0	0	4	4
B	2	Qualified	2	2	0	4
C	3	Qualified	10	0	2	12
D	3	Qualified	3	0	0	3
E	4	Trainee	1	0	0	1
F	5	Trainee	0	4	0	4
G	3	Qualified	0	0	0	0
Total			16	6	6	28

Table 1 shows the breakdown of the three question designs, evidenced by the current analysis, across the collection of questions about what might be helpful. Across the 28 cases, we can see that therapists predominantly used one type of design in their practice, but there is some evidence that therapists employ more than one design (e.g. the therapists in Pair A and in Pair B).

7.6 General discussion

In this chapter, we have examined how therapists design questions inviting clients to give ideas about what might be helpful. As such, these questions represent opportunities for resource-oriented, meta-therapeutic dialogue with respect to methods. The findings highlight a practical dilemma whereby the *minimally softened* and *substantially softened* designs might be considered as merely apparent opportunities for clients to give ideas, since these designs either emphasize the relevance of clients answering independently with no supportive ground preparation or which else provide suggestions/scaffolding which then obscures the relevance of clients giving their own ideas. The findings also illustrate the *softened and de-specifying* design as one route out of this dilemma.

With this latter design, therapists appear to have found a good enough balance between supportively scaffolding the client to answer while still also making a clear space for the client to contribute their own ideas.

A striking finding from the current analysis concerns how the *minimally softened* design occurring alongside participants displaying mismatched expectations regarding what clients can be expected to know about what might be helpful. This mismatch demonstrates how spontaneous, informal opportunities for meta-therapeutic dialogue arising during therapy sessions represent a radical a departure from established norms of expert-therapist, inexpert-client roles (Cooper & McLeod, 2011; Sparks & Duncan, 2016). Furthermore, therapists can also be seen to frequently orient to this mismatch in expectations, since across all of the question designs, they invest at least some work to soften the relevance of the client having to respond with their own ideas. This shows them orienting to the interaction-far recommendation in pluralistic therapy to create dialogical opportunities for talking about what might be helpful while also more or less observably locally anticipating that the client might find this difficult to do. The therapists are therefore already working to adjust the *meta-therapeutic dialogue* initiative to fit the local contexts in which they are working. Clearly, therapists should be supported and facilitated in making these local interactional adjustments if meta-therapeutic and shared decision-making initiatives are to be optimally implemented.

The findings in the current chapter and in Chapter Six go some way towards explaining the infrequency, previously highlighted by Oddli and Rønnestad (2012), of explicit discussions between clients and therapists regarding methods. The current findings indicate interactional factors which may possibly contribute to this infrequency. These interactional factors include mismatched expectations around the client's role and posing of the questions in face-threatening contexts, as well as exacerbation of these factors by minimally softened designs and by unclear opportunities for clients to give their own ideas in the case of substantially softened designs. Creating genuinely dialogical opportunities in the specific context of pluralistic therapy seems to require therapists to sensitively design their questions to soften or mitigate these factors, while still clearly inviting and

displaying the relevance of the client's contributions. As discussed during the analysis, this softening work shows investment on the part of the therapist in making the question as answerable as possible. A striking interactional principle, emerging from the analysis and supported by the current analysis and the work of other CA researchers (e.g. Heritage, 2011; Muntigl, 2016; Voutilainen, Peräkylä & Ruusuvuori, 2010), concerns how the client is more likely to respond affiliatively if the therapist has clearly invested interactional work in making their intervention one the client can easily align with.

To summarize a take-home finding of this chapter: with the *softened and de-specifying* design, therapists create a mutual dialogical opportunity by shifting between constructing the client as less and more knowledgeable and thereby neutralizing issues which contribute to the problematic treatment of the minimally softened design. As will be discussed in Chapter Eight, the therapist's movement between varying constructions and treatments of the client appears to be necessary in creating opportunities for dialogue, which are genuinely feasible for the client to take up.

7.6.1 Summary of implications for practice

This chapter has outlined practical suggestions for therapists who are working towards achieving this therapeutic aim of facilitating, but not constraining, the client to contribute their own ideas regarding what might be helpful. These suggestions include the ongoing need for therapists to be sensitive to the tension between the interaction-far mandate to ask clients for their ideas regarding what might be helpful and the interaction-near considerations of posing these questions in a way which does not presume the client can answer, while still also holding open a clear opportunity for them to do so. Alongside this awareness, therapists should consider how design features impact on the relevance of the client responding with their own ideas, including the need to ensure that the invitation for clients' own ideas – and not therapists' suggestions – are most contiguous with the start of the client's response turn. We have also discussed the desirability of therapists posing these questions in an environment in which the ground has been prepared and the question does not immediately follow an equivocal implicit request from the client.

A general clinical implication concerns the issue of therapist style: I have reported the frequency of question designs across therapists in the current sample. This frequency data enables us to identify that individual therapists may have particular styles when it comes to posing questions about what might be helpful; namely, therapists in the current sample tend to predominantly pose questions using just one of the three designs. This finding serves as a preliminary indication that trainee therapists could potentially benefit from training illustrating these different possible approaches to creating opportunities for clients to participate in meta-therapeutic dialogue.

We have also noted how clients respond to questions about what might be helpful on the basis that if they provide a substantial answer, then they also need to be able to explain why they have produced this answer. This finding that clients treat themselves as accountable for their answers may go some way towards explaining why clients are slow to take on responsibility for providing ideas regarding what might be helpful. One suggestion for practicing stemming from this finding would be to give clients a more comprehensive induction or socialization (Wells, 1997) into why, and how, they might engage in meta-therapeutic dialogue. Furthermore, therapists might consider asking hypothetical questions in order to reduce clients' accountability for giving immediately feasible ideas (MacMartin, 2008; Peräkylä, 1995).

7.6.2 Limitations

The full clinical and interactional significance of questions about what might be helpful can only be fully comprehended after also considering what clients and therapists do in their aftermath. For example, I have reported in the current chapter how clients overwhelmingly respond by treating questions with *minimally softened* designs as non-straightforward and problematic. This treatment opens up the possibility of further disaffiliative actions from clients. Presumably, therapists must be ready to manage this possibility, for example, by working to re-align and re-affiliate with clients so that they once again share common ground. In Chapter Eight, we will explore how therapists and clients manage a range of possible aftermaths following questions about what might be helpful.

This chapter has focused predominantly on how therapists design questions about what might be helpful, with somewhat less focus on the relationship between the design and the local sequential context in which therapists pose these questions. In Chapters Six and Seven, I have considered this relationship in some depth for when therapists pose these questions after clients have equivocally referred to a hoped-for state of affairs. However, aside from this particular analysis and aside from also considering the specific, local context of each individual case, I have not systematically compared features of other contexts and designs across cases and client-therapist pairs. For example, I have not systematically investigated the relationship between *minimally softened* designs and other interactional contexts apart from the one described. There is certainly room for further investigation of this issue. Previous studies (e.g. Ruusuvuori, 2000) have found that recipients can sometimes prioritize responding to a question in terms of its sequential positioning instead of responding in accordance with how the question has been designed. The case is somewhat different for psychotherapy since the sessions are less ostensibly structured than medical consultations, but further investigation is warranted in any case.

7.6.3 Contribution to existing CA research

How participants design and respond to *wh*-questions, and particularly those which make relevant *telling* answers (Fox & Thompson, 2010), is an area still requiring substantial investigation using Conversation Analysis (Hayano, 2013). The findings of this chapter contribute to this investigation and, in particular, to a growing body of findings which demonstrate the interactional difficulties associated with professionals asking *wh*-questions in institutional contexts (e.g. Boyd, 1998; Houen et al., 2016; Leydon et al., 2013; MacMartin, 2008; Muntigl, 2016; Schoeb, 2014; Solberg, 2011; Speer, 2013;Thompson, Howes & McCabe, 2016).

Some of the specific difficulties showing up with *wh*-questions include the manner in which they include presuppositions which clients treat as problematic (e.g. MacMartin,2008; Schoeb, 2014) and the manner in which they can be treated as *testing* of recipients, particularly if the questioner could actually be considered to have some knowledge of the answer (e.g. Houen et al., 2016).

Stokoe and Sikveland (2016) and Feo (2012) also found how future-oriented *wh*-questions were components in interactional frame struggles between professionals and clients, whereby therapists were attempting to achieve a solution-focused or problem-solving framework, whereas as clients moved to continue troubles-telling and/or complaining. The current study has probed some of the reasons as to why *wh*-questions about therapeutic methods are treated as problematic in pluralistic therapy. It seems that when posed with little or no further mitigating material, *wh*-questions tend to be highly presuming that the participant knows about a particular topical agenda, without also investing in ground work for mutual understanding, alignment and affiliation around the this agenda. This finding coheres with Thompson, Howes and McCabe's (2016) conclusion that *wh*-questions may display less empathic understanding than other interventions. In summary, the current findings add to this valuable body of CA evidence which problematizes the oft-cited recommendation for professionals to ask *wh*-questions (i.e. commonly referred to as *open questions*) as an optimal means for eliciting information from recipients (e.g. Cooper & McLeod, 2011).

The findings in this chapter also dovetail with that of Houen et al. (2016) and Huiskes (2016) in demonstrating how professionals can use various levels of epistemic concessions in attempting to elicit answers. The current chapter shows how the *substantially softened* and *softened and de-specifying* designs soften the relevance of the client having to respond independently. In a primary education setting, Houen et al. identified some different practices teachers use when making epistemic concessions after pupils show difficulties responding to *wh*-questions. One such practice was replacing the *wh*-question with the more indirect question phrase "I wonder". In a surgical setting, Huiskes (2016) found that continuing on past the point of possible continuation enables orthopaedic surgeons to epistemically re-calibrate their questions to patients. Trainee orthopaedic surgeons, in particular, tended to recalibrate so that their question encoded less rather than more knowledge than the initial question. In contrast, the current study found that questions with the *substantially softened* design encoded more knowledge than the initial question, and less for the *softened and de-specifying* design. The current findings, alongside Huiskes' and Houen et al.,

demonstrate how question design can be used to work towards distinct professional agendas in varied institutional settings.

Finally, alongside studies such as Houen et al. (2016), the findings of the current chapter demonstrate the value of comparative analyses of differences in how actions are designed in order to highlight interactional dilemmas, in particular institutional contexts, which are recurrently oriented to across participants (Drew, Walker & Ogden, 2013).

Chapter Eight: Managing the aftermath of questions about what might be helpful

8.1 Chapter overview

Having previously examined the prior context (Chapter Six) and the design (Chapter Seven) of questions to clients about what might be therapeutically helpful, this chapter will focus on different scenarios after the client has initially responded. Part One will detail how the same therapist can respond differently after clients have initially misaligned and *have not* substantially answered. In Part Two, we will examine the extended aftermath of two cases in which the client *has* provided a substantial answer. These analyses will illustrate some of the different issues clients and therapists treat as important after a question has been posed. These include whether (and if so, how) the therapist prioritizes pursuit of the client's alignment and how, sometimes, the therapist can move stepwise towards exploring issues outside the room after the client has misaligned with a meta-therapeutic dialogue.

My analyses in this chapter culminate in a conceptualization of different dialogical styles that the therapist can move between, comprising *liberal*, *mutual* and *pursuing*. This conceptualization stems from the issues that participants treat as important, but it also moves beyond participants' moment-by-moment stakes in the interaction since there is no clear evidence that the participants themselves are orienting to dialogical styles while carrying out the interaction. Therefore, the conceptualization of dialogical styles moves beyond the strict remit of CA and into the territory of developing practical and conceptual implications of CA findings, informed by evaluations of what might be therapeutically beneficial (cf. Chapter Three).

The extracts presented in the current chapter are taken from the same therapist's work across two clients (Pairs B and C). While this selection of extracts limits the generalizability of the findings and conceptualizations in this chapter, it also enables us to reflect on how a therapist's practice can change within and across client pairs.

In introducing the analyses in the current chapter, I will briefly indicate the frequency of occurrence of some specific practices in the current collection. However, in this chapter, rather than working to develop a comprehensive typology of cases, I have selected illustrative cases which stimulate a variety of reflective questions for pluralistic, dialogical and collaborative practice.

8.2 Part One: Comparison of immediate therapist responses to clients' misalignment

8.2.1 Abandonment "It's a difficult question isn't it?"

Extract BW illustrates how the therapist can abandon the agenda of a question about what might be helpful in the face of a prolonged lack of verbal response from the client. Such cases of abandonment are very rare in the current sample. I analyse it here in order to elucidate some of the considerations facing therapists when the client does not move to align with the question. Extract BW is taken from 22 minutes into the second post-assessment session. This is the first time in this session that the therapist poses a question about what might be helpful to the client. In Chapters Six and Seven, we have previously discussed the context and design of this question.

As summarized in Chapter Six, in Extract BW, the therapist poses the question about what might be helpful (lines 25-26: "So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the- best (0.3) way °of dealing with=it.°") as a means of shifting the focus to what might be helpful immediately after closing down the client's prior troubles-telling talk.

Extract BW *Session#2/Start22minutes/PairD*

```
20  T:   [°We°'ve both been >talking about] [it and think]ing about it<
21       all the t[ime, and=it's] >going round and round in your ↓head<
22  C:             [Yeah=h       ]
23       (0.3)
24  C:   °Ye:ah°
25  T:   .Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the-
26       best (0.3) way °of dealing with=it.°
27  ?:   .hh °.shih°
28       (6.0)
29  ?:   .PT
```

(1.2)
T: >It's UNpredictable >and it's a difficult
[question isn't=↓it=cause (th-)] .hh you- >DON'T KNOW WHAT HIS
C: [It's ↑very difficult]
T: LETTER's GONNA BE:=
C: =YE:AH h
T: So in a sense you're left THEN (0.6) wondering >WHAT'S he
gonna say<
(.)
C: Uhuh
T: Which is th(hh)en >HIH HIH< WHAT- su[cks all your] ene:rgy
C: [HEH HEH]
T: [isn't it (↓made you ↑think)]
C: [And then (highjack)]
C: ↑Yes ex[↑ACTly]
T: [>°What's he gonna s]ay°< >°what's he gonna say°<
>how['s he gonna >>(say=wee=wee=wee=nuh)<<]
C: [ExACTly if I ↑try and second] ↑guess everything
every scena:ri[o]
T: [Ye]ah
C: .SHIIHH that would take=h for[ever]
T: [>(That it wo]uld)< EH
[HEH HEH ( )]
C: [↑HUH ↑HUH HUH HUH] HUH
T: [So £that's] [not a good] r[oute£]
C: [Heh] [HHH] [.HHH]
(2.0)
T: It DOES FEEL LIKE I mean >I guess what we were talking about
about< your feeling of res:ponsibility for #him .shih .pt is a
real core to it isn't ↓i:t. it's like feeling that .hh (.)
C: °↑Yeahh°
T: You're r-es°ponsible° .hh but >WHAT YOU WERE SAYING THERE< is
is there's something abou:t .hh (.) it stops you worrying
becau:se .hh if you wer:en't (.) >if you're responsible it
feels like you can make things< better for #him
C: ↑Yeah
T: So it sounds like there's a kind of fear that he won't be oka:y
.h
C: °Yeah°=
T: =Or there's fear tha:t, (0.4) ↑is it a fear of °los:ing him?°
C: .HHH=°See I don't kno:w=hh I don't° know .shhih
(9.5)
T: ↑What is it you wanna protect him °from°.
(3.5)
?: .pt

75 (6.0)
76 C: °shih° M:m
77 (6.0)

As outlined in Chapter Seven, the therapist produces the question about what might be helpful with a *minimally softened* design. Almost eight seconds then transpire during which the client does not verbally respond to the question (lines 27-30).This is an unusually long pause in verbal interactions in the current sample of therapy sessions. The client's lack of progression of the interaction shows them treating the question as problematic. The therapist also contributes to the pause by withholding from speaking. In doing so, the therapist is holding the client accountable for responding to the question, and so, is pursuing an answer from the client (Muntigl & Zabala, 2008; Peräkylä, 2011). The lack of a verbal response from the client and the therapist's withholding from speaking creates an interactional impasse which both participants allow to build for almost 8 seconds.

As noted by Muntigl and Zabala (2008), "there is a point in which withholding from speaking may not achieve the desired result of further talk" (p.223). In line 31, the therapist orients to this possibility by taking a turn and breaking the impasse. In this turn, the therapist offers an account for why the client has not answered the question (e.g. lines 31-32 and line 34: "it's a difficult question isn't it because you don't know what his answer's going to be"). This account cites the "difficulty" of the question and constructs the client as not-knowing regarding the question topic ('because you don't know what...'). This provision of an account for the client's non-response is significant since the therapist thereby shows accountability for having asked a question that is somehow problematic (Peräkylä, 1998). In providing this account, the therapist lessens the client's accountability for answering and thereby treats the question about what might be helpful as inapposite at this point (Keevallik, 2011).

Having thus lessened the relevance of the client providing an answer to the question at this point, the therapist moves to re-affiliate by producing a turn (lines 36-37), which the client can align with by confirming (line 39). This turn also makes laughter relevant from the client (lines 40-41), which is one means by which the therapist can move to re-align and re-affiliate with the client

(Jefferson, Sacks & Schegloff, 1987; Muntigl & Horvarth, 2014). The therapist further develops their prior talk as an interpretation using reported speech (lines 45-46), which the client emphatically aligns and affiliates with (lines 47-48, 50, 53, 55) (Bercelli et al., 2008; Weiste, Voutilainen & Peräkylä, 2016). In line 54, the therapist stops engaging in laughter and produces a sequence-closing, affiliatively negative assessment of the reduction ad absurdum made by the client in lines 47-48 and 50. The client orients to the sequence-closing nature of this assessment by discontinuing their laughter after line 55. The therapist then launches a new perspective display from line 57 onwards. This perspective display can be considered an interpretation since it is marked as coming from the therapist's perspective and contains causal and evidential language (lines 62-63: "it stops you worrying because…") (Bercelli et al., 2008; Weiste, Voutilainen & Peräkylä, 2016). However, the therapist ends this turn with a formulation (line 66) and a question (line 69), both of which delimit the relevance of the client's response to confirming or disconfirming that particular formulation and then to answering this particular question. In this way, the therapist has moved to focus the talk on an exploration of the client's experiences. This shift in focus also indexes the therapist's abandonment of the focus on what might be therapeutically helpful.

8.2.1.1 Summary & Discussion In Extract BW, the therapist poses a question about what might be helpful and there follows an eight second impasse during which the client does not verbally respond and the therapist continues to maintain the relevance of the client verbally responding. The therapist then breaks the impasse by accounting for why the client may not be able to substantially answer the question about what might be helpful and then moves to re-establish affiliation with the client by producing turns with which the client can agree and by eventually shifting the focus to explore the client's experiences. These moves by the therapist to re-establish affiliation show an abandonment of the question about what might be helpful in light of the absence of a verbal response from the client during the eight second impasse. Thus in the case of Extract BW, the therapist prioritizes re-aligning and re-affiliating with the client as opposed to attempting to pursue a substantial answer.

In abandoning the question about what might be helpful, the therapist moves towards asking questions which explore the client's experiences outside the therapy room. This move is significant, since the client holds epistemic primacy over these experiences, and so, their accountability for answering questions on this topic is not in doubt (Labov & Fanshel, 1977; Muntigl & Horvath, 2014; Pomerantz, 1980). In this sense, questions about matters in the client's domain constitute safer epistemic and relational ground than questions about what might be helpful, since the client is less likely to respond with a not-knowing or otherwise misaligning response to these questions. As such, this shift in focus back to exploring the client's experiences is a relatively safe move in terms of securing the client's alignment with a new therapeutic agenda. In contrast, attempting to continue a meta-therapeutic discussion at this point could have necessitated the therapist to pursue an agenda with which the client has already substantially misaligned by not producing a verbal response. This raises the likelihood of disaffiliation and relational stress if the therapist were to continue to pursue an answer to the question about what might be helpful.

8.2.2 Preservation and pursuit of alignment "So that'd be the next thing and…"

This section will use Extract HGWGT to illustrate how the therapist can also manage the client's initially misaligned response by working to pursue alignment with the question agenda, including eventually pursuing an answer from the client. Therapists engage in such pursuit work about half the time in the current sample when responding to client's initially misaligning responses to questions about what might be helpful. Extract HDWGT occurs eight minutes into the second post-assessment session

In Extract HGWGT, the therapist asks the client how they might step outside their current social routine and thereby increase their score on a "risk scale" they have just constructed in the session (lines 18-19: "how do we get that up to a hfo(h)ur."). The therapist is thus asking for the client's own ideas regarding what might be helpful in reaching this particular therapeutic goal. One presupposition of this question is that the client agrees that it is a possible and worthwhile goal to "get that up to a four".

The therapist produces the question as a relevant next action after the client has referred to a hoped-for state of affairs (lines 14, 17: "If I can stop- probably two and three." / "°For- (0.3) for-° (0.3) (something like it)"). There is evidence that the therapist is directing the talk here in a solution-focused manner, since the client refers to this hoped-for state of affairs in answering the therapist's previous solution-focused question about change in line 9 ("And d'you- but- (0.8) and: pre↑sumably, you can:: (.) change that"). The therapist's question about "getting that up to a four" is the first reference towards *increasing* the client's level of "risk-taking" in their social life at eight minutes into this session.

Extract HDWGT *Session#2/Start9minutes/PairC*

```
 1  C:   >I  WANNA think of what I'm doing, but (0.4) °↑just
 2       [↑take ] take a wee chance ↑go on ↑go for it.°
 3  T:   [Yea:h.]
 4  T:   .HH
 5  C:   Occasionally.
 6       (.)
 7  T:   Right.
 8       (.)
 9  T:   And d'you- but- (0.8) and: pre↑sumably, you can:: (.) change
10       that.
11       (1.9)
12  C:   I hope I can?
13       (0.8)
14  C:   If I can stop- pro[bably] two and three.
15  T:                     [Yea:h]
16       (0.7)
17  C:   °For- (0.3) for-° (0.3) [(something like it) ]
18  T:                           [So how do we:,      ] how do we get
19       that up to a hfo(h)ur.
20  C:   H ↑↑Hah it's not on=
21  T:   =So >that'd be the ne[xt (thing and)]
22  C:                        [That's        ]
23       (.)
24  C:   ↑I don't know >that's why I came to you: .h No:: that's: [I]
25  T:                                                           [How]
26       >how can we get it up to a four< what would that actually
27       mean.
28       (.)
```

29 T: .shih to do something=I mean in your life at the mo:ment, what
30 would that mean doing (.) that was a bit more risky.
31 C: Say from a work point of view, (0.4)
32 T: Yeah.=
33 C: =I was off for °four months last year°. .hhh and I came back
34 (0.6) and the concentration wasn't there ((continues))

Before the therapist poses the question about what might be helpful, the client has responded with a display of uncertainty (line 12: "I hope I can?"; line 14: "If I can stop") to the therapist's previous solution-focused question. However, in their initial response to the current question of interest in line 20, the client escalates their previous display of uncertainty to a mis-aligning response which problematizes an agenda connected with the question about what might be helpful: "↑↑Hah it's not on". In line 21, the therapist quickly responds to the client's problematizing, by re-framing the question focus as a "next", impending-but-not-yet-current item of business. In effect, this re-framing sequentially deletes the requirement for the client to immediately answer ("So >that'd be the next (thing and)"). However, the client then overlaps to take back the floor in line 22 and the therapist aligns by dropping out. The client uses this turn to develop a not-knowing and misaligning response to the question about what might be helpful, "I don't know what's why I came to you". The therapist then again quickly overlaps to take the floor and pursue a response from the client to the question (lines 25-27). The therapist builds this pursuit by providing subsequent versions of the question about what might be helpful "how can we get that up to a four what would that actually mean" (Davidson, 1984). The client does not immediately respond to these subsequent versions, as shown by the micro-pause in line 28, and so, in lines 29-30, the therapist further pursues a response from the client. From line 31 onwards, the client then begins to furnish a substantial answer to the most recent subsequent version.

I will now examine in more detail how the therapist responds to the client's treatment of the question about what might be helpful as problematic. The therapist twice moves quickly to interrupt the client's development of a misaligning response to the question. With the first such move in line 21 ("So that'd be the next thing and"), they quickly start a turn by latching it on to the end of the client's exclamation in line 20. With this latched turn, they re-cast the question about what might be

helpful as topicalizing an upcoming item of business. This reframes and effectively deletes the immediate response requirement so that the client does not have to respond. As such, the therapist is moving quickly to responsively adjust the response requirements in light of the client's treatment of the question as problematic. Another advantage of quickly taking the floor to re-cast the question about what might be helpful is that it allows the therapist to prevent the client from further developing their initial treatment of it as problematic. Thus by way of this quickly-taken, reframing turn, the therapist can be seen to make a bid to preserve and pursue the client's alignment with the agenda of discussing ideas about what might be helpful.

The therapist's second quickly-taken turn, in lines 25-27, begins in overlap with the client and interrupts their development of a not-knowing response. At the point of overlap, in line 24, the client has moved from problematizing the question agenda ("↑I don't know >that's why I came to you:") towards developing a tentative, not-knowing and potentially more conciliatory position (".h No:: that's: [I]"). In the context of this potentially more conciliatory move by the client, the therapist overlaps to pose a subsequent version of the question and pursue a response from the client (lines 25-27): "[How] >how can we get it up to a four< what would that actually mean." By issuing this subsequent version of the question about what might be helpful, the therapist is now effectively re-activating the requirement for the client to produce ideas in response. As with the first quickly-taken turn, the therapist is working here to pursue the client's alignment with the question agenda in the face of the client's continued development of a not-knowing response. Whether or not the client's not-knowing response is conciliatory, it works to stymie the therapist's efforts to pursue ideas from the client. The therapist's overlapping turn thereby shows that they are not yet prepared to accept a definitive (even if conciliatory) not-knowing response from the client.

Both latching and overlap are quickly-taken turns and work to pursue the agenda of the latching and overlap and the client's alignment with this – even in the face of the client's problematizing. The specifics of this pursuit work are responsive to the immediate context. The latched turn reframes and sequentially deletes the response requirements given the client's exclamation that the question agenda is not viable. In the context of such explicit misalignment,

straightforward pursuit at this point would likely just perpetuate it. Thus the therapist effects a temporary retreat and sequentially deletes the response requirements, which move preserves the potential of re-alignment in the ensuing interactions. Indeed, subsequently, the therapist's second quickly-taken turn, began in overlap with the client, re-activates the requirements and pursues a substantial answer from the client. Both turns indicate the quick-footed work done by the therapist to preserve and pursue the question agenda and the client's alignment with this.

The therapist's pursuit by posing subsequent versions of the latching and overlap comprises another responsive adjustment in the face of the client's problematic treatment (MacMartin, 2008). As we have seen, this pursuit occurs onwards from line 25 when the therapist overlaps with the client to pose a subsequent version. With this pursuit, the therapist orients to the relevance of the client answering the question. Indeed, prioritizing this relevance overrides the therapist's initial use of "we" (lines 18, 26), which might otherwise construct the talk as topicalizing an issue for which both the therapist and client are responsible for discussing. In addition, from halfway through line 29, the therapist also switches from the use of "we" to "your". This latter pronoun, referencing only the client, is more consistent with the therapist's pursuit of an answer from the client.

Aside from this pursuing function, the specific adjustments the therapist makes in these subsequent versions also indicate which parts of the original latching and overlap they are treating as potentially problematic for the client (Davidson, 1984). The therapist's subsequent versions here soften the requirements for the client to independently produce immediately feasible ideas regarding what might be helpful. For example, in the first subsequent version (lines 25-27), the therapist alleviates the requirement of immediate feasibility for any suggestions the client makes by replacing "do" with the more hypothetical "can". The therapist's subsequent versions of the latching and overlap also provide some scaffolding to the client regarding what might count as an adequate answer. This scaffolding means that the client does not have to independently produce content. This scaffolding is built up through specifying that the client is being asked about what "getting it up to a four" would "actually mean" (lines 26-27) in their "life at the moment" (line 29), including "what this would mean doing that was a bit more risky" (line 30).

With these subsequent versions, the therapist walks a fine line between continuing to treat the client as accountable for answering the latching and overlap, while nonetheless providing scaffolding regarding what might count as an answer. In doing so, the therapist holds open a space for the client to respond with their own ideas while still also providing further specification to address any potential inadequacies in the original question. These subsequent versions can be viewed as responsive and affiliative adjustments given the client's initial problematizing response.

8.2.2.1 Summary & Discussion Extract HDWGT is one of a substantial number of cases in the current sample in which therapists work to preserve the relevance of the agenda of the question about what might be helpful and pursue the client's alignment with it after clients have initially responded by treating it as problematic. In Extract HDWGT, these practices include two quickly-taken turns by the therapist. The first of these reframes, and effectively deletes, the response requirements in the face of the client's initial misaligning exclamation, and the second turn quickly launches a pursuit of a substantial answer in overlap with the client's development of a not-knowing position. Common to both of these quickly-taken turns is the therapist's work to preserve the relevance of the question agenda as something the client can align with and then to pursue the client's alignment with this.

In Extract HDWGT, the therapist also uses *subsequent versions* of the question about what might be helpful to pursue an answer from the client. This pursuit by therapists can be considered *responsive* since by issuing subsequent versions, therapists orient to the initial question as not having been optimally answerable. The subsequent versions are, in effect, responsive adjustments to make the question more readily answerable so that the client can align with it. In the case of Extract HDWGT, we have seen that the therapist works to make the question more answerable by providing more scaffolding so that the client is not required to independently produce an answer. These adjustments are informative regarding what the therapist is treating as the potential points of difficulty in the original question. Providing further scaffolding in a subsequent version to first version which was minimally softened evidences the ongoing relevance of the issues explored in Chapter Seven, in particular that practical dilemma between a minimally softened question design

which makes clearly relevant the client's own ideas but at the risk of being treated as highly problematic by the client. The ongoing relevance of this dilemma while constructing subsequent versions of questions evidences its ubiquity for pluralistic therapists.

We further noted how this pursuit by the therapist occurs alongside their initial use of the "we" pronoun. *Prima facie*, "we" would appear to signpost a collaborative endeavour and yet the therapist can be seen to continue to pursue the client's ideas despite the client's development of a not-knowing response. In the general discussion for Part One, we will return to this question of whether and how pursuit might be considered to promote a mutual dialogue with the client given an initial not-knowing response.

In contrast to the therapist's work to pursue alignment with the question about what might be helpful in the face of the client's initial problematic treatment of it, we will now look at another case, in which the therapist manages the client's not-knowing response by leaving space as opposed to working to immediately pursue an answer.

8.2.3 Leaving space and affiliating with misaligning response "It does, doesn't it?"

This section will illustrate how the therapist gives the client plenty of space to develop their problematic treatment of the question about what might be helpful and subsequently affiliates with this problematic treatment. The therapist's alignment with the client's problematic treatment here contrasts with the therapist's responsive pursuit in Extract HDWGT. Instances in which therapist gives the client plenty of space to develop the misaligning response occur quite infrequently in the current sample.

Extract HCYDT/Part One is taken from 30 minutes into the second post-assessment session. The therapist poses a *minimally softened* question about what might be helpful in line 36: "h. >And I guess< and ↑how- ↑how can you do that?" This is immediately after the client has ended their turn by referring to a hoped-for state of affairs, ">I want it to be the ↑#other #way #ar↑ound<" (line 31). However, as discussed in depth in Chapter Six, the therapist's subsequent *minimally softened* question about what might be helpful prioritizes a problem-solving framework and de-prioritizes

affiliating with the client's troubles-telling or responding with a more substantially helpful response such as a suggestion. As detailed in Chapter Seven, the client treats the question about what might be helpful as problematic to answer. They achieve their misaligning and disaffiliative response by firstly claiming a lack of knowledge (line 40) and then disaffiliatively producing an answer, interspersed with complaint-elements and constructed as practically impossible (lines 42-45). This complaining, practically impossible construction incorporates the use of extreme case formulations ("all the time", "every emotion") and the negative assessment ("that sounds a hell of a lotta work").

Extract HCYDT: Chapter Nine, Part One *Session#2/Start34minutes/PairD*

```
31  C:    [>I want it to] be the ↑#other #way #ar↑ound<
32  T:    [Ye:ah       ]
33  C:    SHHih. HHHEHH[h ]
34  T:                 [Ye]:ah
35  C:    hh. .shhih
36  T:    h. >And I guess< and ↑how- ↑how can you do that?
37  C:    °.shhhih M::m,° (0.8) °°brain transpl[ant°°  ]
38  T:                                         [heh heh] [heh hahhah] hah
39  C:                                                   [hih hah hah]
40  C:    °Oh God° .hh hh (0.8) °I dunno:°
41        (1.0)
42  C:    ↑Being in a state of hypervigilence all the ↑time, and then
43        sitting down and examining every emotion and .hh whether it's
44        valid or just (.) non↑sense? .hshih °°that sounds°° a hell of
45        a lotta wo[rk.]
46  T:              [It ]does doesn't i:t?
47  C:    °Uh ha:h° >but it's<- it #actually sounds quite
48        necess(hh)AR(hih)Y wo(hhh)rk. (.) .shh[ih ]
49  T:                                        [.hh]hh Well I guess
```

The therapist does not intervene before the client has finished their response. Indeed, the therapist not only refrains from overlapping with the client's increasingly disaffiliative response, but also does not take up the opportunity to take a turn at several transition relevance places, for example, in line 40 in the (0.8) gap after the client's "oh God" and in- and out-breaths and in the (1.0) gap after the client's claim that they "dunno". By withholding from taking a turn at this point, the therapist treats the client's response as expandable and thus creates the opportunity for the client to further

develop their response (Muntigl & Zabala, 2008). However, as we have seen, the client initially continues to provide a disaffiliative response which constructs their answer as practically impossible in a complaint-implicative manner. For example, they produce a negative, complaint-implicative assessment of their own answer to the question about what might be helpful (lines 44-45: "°that sounds a hell of a lotta work°").

Significantly, the therapist here responds in a highly affiliative manner to the client's disaffiliative answer. They do this in line 46 by agreeing with the client's negative assessment and by producing a tag question which invites the client to re-confirm their own negative assessment ("It does doesn't i:t?"). In response to the therapist's affiliative agreement, the client now produces a contrastive assessment: "but it's- it #actually sounds quite necess(hh)AR(hih)Y wo(hh)rk " (lines 47-48). This new assessment contrasts with their previous complaint-implicative assessment, since they now assess as "necessary" the work that they had previously assessed as practically impossible. In effect, the client now reconstructs their previous suggestion as seriously worth considering. This re-assessment by the client thus moves towards re-affiliation with the therapist. In this way, we can see how the therapist's actions, firstly, of withholding from taking a turn while the client is developing a disaffiliative answer, and secondly, of affiliating with the client's disaffiliative answer can actually then lead to a scenario in which the client reconstructs their suggestion as one offered in a serious attempt to answer the question about what might be helpful.

8.2.3.1 Summary & Discussion In Extract HCYDT/Part One, the therapist manages the client's problematic treatment of the *minimally softened* question about what might be helpful in two ways. This first is to withhold from responding to give the client the opportunity to fully develop their response and the second is to affiliatively agree with the client's negative, complaint-implicative assessment of their own answer. These two practices create a space in which the client can fully develop their initial misaligning response. Notably, the client then more affiliatively reframes their initial misaligning response as actually describing "necessary work".

These actions by the therapist are similar to cases Muntigl et al. (2013) have labelled as *active retreating* – wherein therapists move to re-affiliate with clients after the client has disagreed with the therapist's formulation. The similarity consists in the particular actions of leaving the client space to fully develop their misaligning response before then moving to align and affiliate with this. Of course, the therapist's actions in Extract HCYDT/Part One differ from *active retreating* in that the therapist is not retreating *per se* from a formulation they have developed. Instead, the therapist here just refrains from pursuing the client's alignment with the agenda and presuppositions of the question about what might be helpful. Refraining from such a pursuit and instead leaving space for the client to fully develop their misaligning response, shows the therapist more lightly and flexibly holding the question agenda at this point – holding the client's ideas about what might be helpful as a possible, but not a necessary, focus for the interactions.

8.2.4 Clinically-focused discussion

The questions about what might be helpful in these three extracts are all produced with a *minimally softened* design. As discussed in Chapter Seven, the relatively demanding response requirements of this design likely goes some way towards explaining their treatment by clients as problematic. However, there is a striking contrast between how the therapist manages the client's initial treatment of the question about what might be helpful as problematic across the three extracts: abandonment of the question agenda in Extract BW versus pursuit of alignment with the question about what might be helpful in Extract HDWGT versus leaving space for the client to comprehensively develop their treatment of the question about what might be helpful as problematic and then moving to align and affiliate with this (HCYDT/Part One). *Prima facie*, these are vastly different practices for managing the client's initial misalignment with the question about what might be helpful. I will first explore some more specific clinical implications of these vastly different practices before focusing on some broader contextual issues around this finding.

8.2.4.1 Conceptualization and comparison of dialogical styles Eventually, the clients in both Extracts HCYDT/Part One and HDWGT attempt to substantially answer the question about what might be helpful. However, the two extracts illustrate two very different flavours of interaction – the facilitation of a liberal and permissive space in which the question agenda of the client giving ideas about what might be helpful is lightly held versus a quick-paced pursuit of this agenda. With the *liberal* or permissive style, the client is free to display doubts about whether anything might be therapeutically helpful and perhaps even to freely describe whether they are ready to engage with the question agenda at this point. Thus the therapist here facilitates the client's autonomy in responding in whatever way they see fit and, as such, prioritizes a client-centred exploration in which the client can start to become their own therapist. In contrast, with the *pursuing* style, the therapist moves to cut off the client from fully expressing doubts about the question agenda. Instead, this pursuing style prioritizes eliciting an agenda-aligning contribution from the client, and so, keeps the focus firmly on what might be helpful in addressing the client's difficulties and issues. It can be argued that this pursuing style facilitates the client's autonomy in a different sense – if the therapist accepts a not-knowing response from the client without further pursuing an answer, this might actually disempower the client, since they will have been deprived of an opportunity to develop and contribute their own ideas. In this conceptualization of autonomy, a role is retained for the therapist's knowledge and judgement regarding what it is more beneficial for the client to focus on at this particular time.

In effect, there are two distinct dialogical styles or moves or moments visible across Extracts HCYDT/Part One and HDWGT. A more *liberal* style fully acquiesces to the client's current experiences and preferences and the importance of fully exploring these, whilst another *pursuing* style incorporates the therapist's expertise in choosing what to focus on at this particular point. Pluralistic therapy endorses both of these styles in the sense that it promotes respect for the client's experiences and preferences while also recommending *mutual* meta-therapeutic discussion or dialogue, to which *both* the therapist and client contribute. The current findings therefore go some way towards illustrating the complexity of attempting to concretely implement broad mandates like

dialogue and they illustrate some issues at the heart of attempting to implement them in concrete practice: Can dialogue be achieved if the therapist is working *not* to accept the client's initial misaligning response as definitive? Just how mutual and dialogical is the client's eventual answer if it is obtained by the therapist's quickly-taken, pursuing actions? And yet, on the other hand, the therapist's pursuit shows them responsively adjusting the question about what might be helpful to make it more readily answerable and, of course, it may be necessary to pursue an answer if the question was not initially optimally designed. The recurring theme underlying these questions consists of whether, and how frequently, a pluralistic therapist should pursue an answer to a question about what might be helpful as opposed to leaving space for the client to fully develop a misaligning response which may even challenge the question agenda.

In concrete practice, such professional mandates such as *dialogue* inevitably leave a lot to the judgement of the individual therapist at any particular point and this judgement can lead to very different flavours of interaction. One use of the current findings in pluralistic training would be to highlight the complexities involved in mutual therapeutic practice. For example, by asking trainees to reflect on different possible dialogical styles, the possible advantages and disadvantages of each and the different circumstances in which they might be employed.

8.2.4.2 Therapists switching between dialogical styles Moving now to some broader contextual considerations, the extracts in Part One show the same therapist heterogeneously managing clients' misaligning responses. Extracts BW and HCYDT/Part One occur thirteen minutes apart in the same session for Pair C while Extract HDWGT occurs in another session with a different client, Pair B. In the extracts shown for Pair C, the therapist temporarily abandons the meta-therapeutic focus after the client's first misalignment. When the therapist then re-introduces this focus thirteen minutes later, they show a liberal acceptance of the second instance of the client mis-aligning with the question about what might be helpful. In contrast, it seems that this therapist at times adopted a more pursuing style with the client in Pair B/Extract HDWGT. This possibility is certainly not comprehensively evidenced in the current chapter, but it nevertheless raises some interesting issues

for practice. Would such different styles be due to an explicit agreement between therapists and clients to use different therapeutic approaches? If this were the case, then this might be a source of evidence that therapist is responsively adjusting their interventions across individual clients. However, it is also possible that there might be more implicit factors at play here, such as clients' varying social positionings (e.g. gender, class, ethnicity) in relation to the therapist. Clarifying the extent of these possibilities certainly require further research.

Dovetailing with our earlier discussion of distinct dialogical styles, even if a client agrees to a more pursuing or challenging approach from the therapist, how far should such an approach extend if there is evidence in the moment-by-moment interactions that the client is resisting? Although the client may have agreed to a more challenging therapeutic approach, the pluralistic approach also makes space for the possibility that the client might find different approaches differentially helpful at different times (Cooper & McLeod, 2011). These considerations provide further impetus for the recommendation first made in Chapter Five which was that trainees should be sensitized to the various forms of interactional resistance which can be shown by clients and that therapists should be encouraged to check in with clients' current experiences if interactional resistance begins to emerge.

Turning now to the finding that the same therapist employed different styles of managing the client's misaligning responses in the *same* session - Extracts BW and HCYDT/Part One represent the only two questions about what might be helpful posed in that particular session. After the client does not verbally respond all to the first question about what might be helpful, the therapist uses a more liberal style when managing the client's misaligning response to the second question about what might be helpful thirteen minutes later. One possibility here is that the client's reception of previous questions about what might be helpful impacts on how the therapist manages further misaligning responses from the client to any subsequent questions about what might be helpful. This shows how therapists may responsively adjust their interventions as the session progresses based on how the client responded previously. Again, the current findings only indicate – as opposed to substantially evidencing – this possibility. Best practice guidelines still need to be

developed regarding how pluralistic therapists might manage multiple posings of questions about what might be helpful if the client had initially misaligned. Again, a guiding consideration here concerns the dialogical ethics of whether and how much the pluralistic therapist should pursue the client's contribution to talk about what might be helpful.

8.3 Part Two: Comparison of different managements of extended aftermath

The findings in Part One have focused on how therapists manage the immediate aftermath of a client's misaligning response to a question about what might be helpful. In Part Two, we will examine how the therapist manages the more extended aftermath of questions about what might be helpful after the client has provided a more substantial answer.

8.3.1 Perspective display by therapist "Well I guess part of it is about…"

We will firstly examine how the therapist in Extract HCYDT/Part Two produces a perspective display of their own regarding what might be therapeutically helpful. As discussed in Extract HCYDT/Part One, the client positively reassesses their answer in lines 47-48, which they had previously constructed as practically impossible. However, the client now retrospectively frames it as a serious, substantial answer to the question about what might be helpful: "but it's- it #actually sounds quite necess(hh)AR(hih)Y wo(hh)rk ". We will now focus on the conversational turns ensuing after the client's aligning, re-assessment.

Extract HCYDT: Chapter Nine: Part Two *Session#2/Start34minutes/PairD*

```
47  C:   °Uh ha:h° >but it's<- it #actually sounds quite
48       necess(hh)AR(hih)Y wo(hhh)rk. (.) .shh[ih ]
49  T:                                        [.hh]hh Well I guess
50       part of it >is about being<- I mean I think >this=is
51       exactly what you're doing< at the moment which is (0.6)
52       kinda noticing what those kind=of (0.5) voices a:re,
53  C:   [M:m      ]
54  T:   [>And then] I guess you know he:re or (in) >places like th#is<
55       having the chance to kind of think through it and actually
56       say (.) does this make sense or not, .hh and then, (0.3)
```

57 h#opefully next time that v#oice comes up, .hh
58 C: °Yeah°=
59 T: =Saying you kno:w (.) I've done a terrible thing h#ere .hh
60 >actually kinda remindin' yours#elf< ok hh. when I sat down
61 (.) and when I thought this thr#ough, (.) rea:lly carefully
62 .hh took everything into acc#ount, (1.0) actually, (0.4) it's
63 >not a terrible thing.<
64 C: Mhm
65 T: °You know,°
66 (0.7)
67 T: And that's kind of a process we=can go through again and again
68 if necessary .hh because what we've done is >to just kinda<
69 rea:lly l#ook at that °a:nd say .hhh is it a terrible thing
70 you're do#ing, (0.4) hhh. and=
71 C: =°Mhm°=
72 T: =it- (1.0) it, (.)↑isn't.
73 (.)
74 C: No.
75 T: It isn't it (c[an't]) (1.2) you know th-=it- (2.4)
76 C: [uhuh]
77 T: hh. >THAT'S NOT TO SAY it's not hurtin' him.
78 C: .pt <Tha:t's (0.4) the point> y[e:ah]=
79 T: [Ye:ah]
80 C: =Uhuh I think I'm conflat[ing those two th]ings hhh. Mhm.
81 T: [Ye::ah]
82 T: Ye:ah.
83 C: His hurt and my action.
84 T: Yeah.
85 (1.6)
86 T: Because it is- yeah i- I'm sure he would be happier, .h
87 (0.7) at least in the short term if you said ((continues))

The client's re-assessment in lines 47-48 has turn-final intonation and ends with a fairly substantial sniff. In line 49, the therapist overlaps with this sniff and then begins to describe a possible answer to the question about what might be helpful, that is, a "process" (line 67) that might be helpful for the client. The therapist marks this advice-implicative turn as a perspective-display on their part (e.g. lines 49-50: "Well I guess part of it >is about..."). The perspective-display extends from line 49 to at least line 72, with the client issuing continuers at lines 53, 58, 64 and 71. There is evidence that the therapist is pursuing a more substantial response from the client and that the client is resisting doing

this. For example, in line 65, the therapist assumes a shared understanding ("°You know°") (Hepburn & Potter, 2011a; Edwards, 1997) and leaves a 0.7 second pause during which the client does not verbally confirm this understanding. The therapist then begins another turn designed as an increment to the previous one ("and that's kind of a process we=can go..."), which is a common means of pursuing more substantial uptake from the recipient (Bercelli et al., 2008; Ford, Fox & Thompson, 2002; Pomerantz, 1984a). One possible reason that the client is not responding substantially emerges later in line 77 when the therapist rushes in to qualify their perspective-display: ">THAT'S NOT TO SAY it's not hurtin' him". This qualification shows the therapist orienting to a possible problem in what they have been saying such that the client has not yet substantially responded. In lines 78, 80 and 83, the client offers extended agreement with the therapist's qualification and the two move away from meta-therapeutic considerations by beginning to explore the client's experiences around "conflating those two things" (line 80 onwards).

In sum, in Extract HCYDT/Part Two, the therapist produces a perspective-display of their own immediately after the client has answered the question about what might be helpful. The therapist then pursues substantial agreement with their perspective-display from the client but the client resists doing so. I will now analyse the therapist's pursuit of agreement and client's resistance in greater detail. Subsequently, in the following Summary & Discussion section (8.3.1.1), I will elucidate some features of clinical importance arising from this analysis.

That the therapist's perspective-display starts with a "well"-preface in line 49 already projects a disagreement between the client and therapist regarding what might be helpful. This is since a "well"-preface projects that the current speaker's perspective will be privileged over the prior speaker's (Heritage, 2015). One reason for this "well"-preface may stem from the similarity in content between the therapist's suggestions for what might be helpful and the client's initial complaint-implicative ideas, which they constructed as practically impossible. An example of this similarity in content consists of the therapist's suggestion in lines 55-56 that the client "think it through" and consider "does this make sense or not", when the client in lines 43-44 (in Extract HCYDT/Part One) had suggested "examining every emotion and whether it's valid". Thus, with the

"well"-preface, the therapist may be projecting an upcoming disagreement regarding this similarity in content, given the client's previous construction of similar content as practically impossible.

The therapist's initial projection of disagreement is substantiated when the client is indeed slow to display unequivocal, extended agreement with the therapist's perspective-display. Consequently, the therapist invests substantial work from line 49 until line 75 in attempting to secure such agreement. This appears similar to Bercelli et al.'s (2008) findings about how therapists pursue extended agreement from the client after initially developing an interpretation. Alongside the therapist's addition of an increment to their perspective display (from line 67) and several appeals to shared understanding (i.e. use of "you know" in lines 54, 59, 65, 75), the therapist also uses some script proposals in a bid to secure agreement (Butler et al., 2010). An example of a script proposal runs from lines 59-61: "Saying you kno:w (.) I've done a terrible thing here .hh >actually kinda remindin' yourself< ok hh. when I sat down (.) and when I thought this through..." With this script proposal, the therapist changes footing to use the client's voice to render the content of the suggestion more readily agreeable for the client (Ekberg & LeCouteur, 2014a; Sandlund, 2014). In addition, the therapist's concession to the client in line 50-51 ("I mean I think this is exactly what you are doing at the moment") and their qualification in line 77 (">THAT'S NOT TO SAY it's not hurtin' him") also show them working to pursue substantial uptake from the client. The fact that the client withholds this agreement in the face of the therapist's pursuit shows resistance to doing so (Heritage & Sefi, 1992).

The therapist also projects that the client might disagree by frequently incorporating epistemic downgrades in their turn, including "I guess" (e.g. line 49), "hopefully" (line 57), "actually kinda remindin' yourself" (line 60), "a kind of a process" (line 67) and "just kinda really look at" (lines 68-69) (Ekberg & LeCouter, 2014a). Indeed, the phrase "just kinda really look at" in lines 68-69 illustrates the cross-cutting nature of the therapist's pursuit here. On the one hand, it is epistemically mitigated ("just kinda"), which lessens the therapist's epistemic authority over the precise nature and truth value of what they are suggesting, but on the other hand, it is built persuasively – the phrase "really look at" implies that the therapist's suggested course of

therapeutic action is worthwhile and distinctive. Thus, the therapist's packaging of their perspective-display can be described as mitigated pursuit work, or perhaps, as *supportive disagreement* as identified by Weiste (2015). This mitigation shows that the therapist is not authoritatively taking the client's agreement for granted, while the pursuit work still also demonstrates they are working hard to pursue the client's agreement to their suggested course of action.

As we have seen, in withholding from substantially responding in lines 49-77, the client is resisting displaying unequivocal agreement with the therapist's perspective-display. In line 78, the client does agree with the therapist's qualification, "<That's (0.4) the point> ye:ah". However, the agreement token "yeah" is turn-final and consequently delayed, which shows the client asserting their agentic and epistemic rights over the content of the therapist's qualification (Raymond & Heritage, 2012; Muntigl & Horvath, 2014). Furthermore, in agreeing with the therapist's qualification in line 78, the client has, in effect, avoided having to agreeing with the therapist's perspective-display as a whole (Peräkylä, 2005). The client then goes on to provide extended agreement with the therapist's qualification by reporting their analysis regarding "conflating those two things" (line 80 onwards). From line 86, the therapist also takes up this focus (Peräkylä, 2005) . This represents a shift in focus from meta-therapeutic talk about what might be helpful to the client's experiences outside the therapy session. As discussed in Part One of the current chapter, this type of exploration in which the client is the undisputed, primary expert on their experience is safer epistemic and relational ground than the therapist continuing to pursue an agenda with which the client is misaligning.

8.3.1.1 Summary & Discussion In Extract HCYDT/Part Two, the therapist responds to the client's perspective-display regarding what might be helpful by launching a perspective-display of their own. The therapist prefaces this perspective-display in a way that projects disagreement from the client and, indeed, the client does not substantially respond. The therapist then continues to develop their perspective-display in a way that pursues extended agreement from the client, albeit in a somewhat mitigated manner. The client eventually agrees in a manner which asserts their epistemic primacy. In

a move away from meta-therapeutic talk about what might be helpful, the client and therapist then shift to exploring the client's experiences about issues beyond the therapy session. As noted in Part One of this chapter, meta-therapeutic talk is sometimes not sustained by participants if the client is misaligning with this.

Findings from our analysis of Extract HCYDT/Part Two have illustrated the mitigated nature of the therapist's pursuit – on the one hand they are clearly pursuing the client's agreement with the suggestion they have just put forward regarding what might be helpful. However, on the other hand, they are observably doing this in a mitigated manner which detracts from their authority and shows openness to other versions of reality, for example, as evidenced by their frequent use of epistemic downgrades such as "kinda". Nonetheless, mitigated pursuit is still fundamentally pursuit. Practices like script-proposals and frequent uses of "you know" work to pursue the client's agreement, even if this pursuit is also epistemically downgraded. Indeed, such downgrading or mitigation may also be a form of pursuit since it works to achieve broader acceptance from the recipient and evade potential criticisms (Brown & Levinson, 1987). There is a need to ensure that therapists are fully aware of the pursuing nature of some of their interventions. This is especially the case when the therapist is endorsing a particular therapeutic approach, since such pursuit implicitly pressures the client to agree with the therapist. The current findings can be used to help therapists and trainees to develop an awareness of what pursuit looks like interactionally, so that they can engage in such practices in full awareness that the interactional effect is to pursue agreement from the client regardless of how it might appear mitigated.

In our analyses of Extract HCYDT/Parts One & Two, we can also observe a movement from the *liberal* dialogical style displayed in Part One of this extract to the more *pursuing* style being prioritized in Part Two. In Part One, the therapist liberally left space for the client to develop their misaligning response. However, in Part Two, the therapist follows the client's re-aligning reassessment with a perspective-display of their own. The style here is potentially more *mutual* since it involves the therapist meeting the client's perspective-display with one of their own. However, the therapist then pursues the client's extended agreement. This pursuit makes it relevant

for the client to now agree with an approach which they have recently constructed as practically impossible. That the therapist projects disagreement from the outset of this pursuit shows the *pursuing* style being prioritised here. This movement from more liberal to more pursuing styles illustrates the dynamic and ongoing movement of dialogical positions in therapeutic talk. After giving the client some space to misalign with the question about what might be helpful in Extract HCYDT/Part One, the therapist then foregrounds their own ideas about what might be helpful. Mutuality, of course, necessarily involves the therapist's contribution of their ideas and expertise. However, in the current case, in responding to the therapist's perspective-display, the client must additionally negotiate the therapist's pursuit of agreement from them. This creates a less liberal response space in which the client is somewhat constrained in how they respond to the therapist's ideas. Again, an increased awareness of what pursuit looks and feels like interactionally may help therapists to facilitate more liberal response spaces for clients. As illustrated by our analysis of the softened and de-specifying question design in Chapter Seven, it is possible for the therapist to introduce content (e.g. suggestions or scaffolding) while still also de-specifying and liberalizing the client's response space.

Across Extract HCYDT/Parts One and Two, there is evidence that the client utilizes varying epistemic positions in order to misalign with, and eventually to avoid agreeing with, the agenda of their giving ideas about what might be helpful and, subsequently, the therapist's perspective-display regarding this. In Chapter Seven, we examined how the client in this extract initially misaligns with the question about what might be helpful by declaring a lack of knowledge and then disaffiliatively constructs a candidate answer as practically impossible. Their declared lack of knowledge displays initial alignment with the question agenda. However, their subsequent construction of an answer as practically impossible (and then in their re-assessment as "necessary") then positions them as knowledgeable and authoritative about the content of this candidate answer in the first place. This more knowledgeable position enables them to further misalign with the question agenda of giving their own ideas about what might be helpful. In the current Extract HCYDT/Part Two, we see the same client further asserting their epistemic primacy by refraining from substantially responding to

the therapist's perspective-display until the therapist offers a qualification. Taking up this qualification then enables the client to avoid agreeing with the therapist's perspective-display *per se* and to sidestep into an exploration of their experiences beyond the therapy room. Thus, in moving from less-knowledgeable to more knowledgeable positions, the client firstly misaligns with the question agenda and secondly and avoids agreeing with the therapist's endorsement of a possible therapeutic strategy.

This illustration of the client's epistemic manoeuvrings also indicates how it is possible for clients to participate in talk about what might be helpful while still refraining from fully endorsing the usefulness of such talk (Peräkylä, 2005). This possibility is clinically important since it might otherwise go unnoticed if the client's participation was viewed using an interaction-far lens. Therapists need to be sensitive to this possibility that client participation may nonetheless index a less-than-full endorsement. This possibility is especially important since an associated implication is that meta-therapeutic talk may not always occur in ways that feel genuinely relevant and useful to the client. Training could also be provided to help sensitize therapists as to when the client has observably misaligned during meta-therapeutic talk. Therapists could then be encouraged to topicalize how the client is currently experiencing this meta-therapeutic discussion, which then opens up the possibility of adjusting how these discussions are being conducted to personalize them to what feels helpful for that particular client. For example, it may be that the client would prefer to postpone this discussion until the next session so that they can have more thinking time or focus on something else in the current session.

In Extract HCYDT/Part One, there is an observable shift away from meta-therapeutic talk towards discussing the client's experiences outside the therapy room. As previously discussed in Section 8.2.1.1, this represents a safer relational and epistemic ground. Peräkylä (2005) noted a related practice in which psychoanalysts sometimes and endorsed and developed patients' uptake of a point that seemed ancillary to the new material put forward in the therapist's interpretation. In the current data, such a shift to an ancillary focus also means that there is no explicit discussion at this point of the client's observable, ongoing misalignment with the agenda of sharing ideas

regarding what might be therapeutically helpful. Towards the end of the current session, the therapist does make a meta-therapeutic suggestion that the client keep a thought record and the client agrees this would be helpful. However, there is otherwise no explicit topicalization of the client's previously displayed ambivalence towards this therapeutic approach. It may of course be that in the case the therapist and client are prioritizing other therapeutically important and necessary activities and that they will return to a discussion of this at a later time. The current recommendations to engage in meta-communication about meta-therapeutic talk are therefore directed towards the possible scenario in which this discussion is not reconvened. Alongside the advantages outlined in the paragraph above, a further advantage of explicitly exploring how the client is experiencing the current talk about what might be helpful is the creation of an opportunity for the client to explore their uncertainties and ambivalence regarding the meta-therapeutic agenda and what is therapeutically possible in the first place.

8.3.2 Maintaining and extending focus on what might be helpful

Extract WBRH is an exceptional case in the current collection in which talk about what might be therapeutically helpful extends for several minutes after the initial question about what might be helpful.

In Extract WBRH, we join the session as the client has shifted within their own extended conversational turn to talk about what might be therapeutically helpful. In line 4, the client shows they have finished their discussion of this topic with an assessment and turn-final intonation: "°It h#elped a b#it b#ut, (0.6) no.°". Here the client negatively assesses the helpfulness of therapeutic approaches they have previously tried. With this negative assessment, the client positions themselves as not-knowing regarding how to find approaches that would be helpful. Similarly to the other cases we examined in Chapter Six, this creates an opportunity for the therapist to somehow provide a helpful response. In line 6, the therapist fills this slot by asking the question about what might be helpful, "What- >>↑do you have a ↑sense<< of what would be really helpf°ul for you.°". With the question word "What-", the therapist initially begins to produce this question with a

minimally softened design. However, they immediately abort this start and begin again with a yes-not interrogative ("↑do you have a ↑sense..."), which is less presuming regarding whether the answer falls in the client's domain. This same-turn repair indicates that the therapist is already anticipating here that the client might have difficulty substantially answering a *minimally softened* question about what might be helpful (Drew, Walker & Ogden, 2013). Indeed, in lines 8-10, the client does produce a display of difficulty in answering the question. In line 11, similarly to Extract HDGWT, the therapist begins a question which would probably have pursued an answer from the client. However, the client then starts to respond and the therapist drops out. In this response, the client misaligns with the question about what might be helpful by disaffiliatively challenging the presupposition that they can answer it: "If I KNEW what would be helpful I'd,] (0.4) °I could go° and ge:t it" (lines 12-14). Up until the end of line 20, the client further develops this misaligning and disaffiliative response and the therapist facilitates this by refraining from taking the conversational floor.

Extract WBRH *Session#0/Start29minutes/PairC*

```
 1  C:   °I just° (0.4) then she w#ent through a c#ouple of ex#ercises,
 2       and breath#ing, (.) exerc#ises °as we:ll, and that was,°
 3       (2.3)
 4  C:   H#elped a b#it b#ut, (0.6) °no.°
 5       (0.4)
 6  T:   .pch What- >>↑do you have a ↑sense<< of what would be really
 7       helpf°ul for you.°
 8       (1.8)
 9  C:   HHHHH
10       (0.8)
11  T:   What is i[t (y-                          )][Mm: ]
12  C:             [If I KNEW what would be helpful][I'd,]
13       (0.4)
14  C:   °I could go° and ge:t it.
15  ?:   .SHHIHH
16       (0.5)
17  C:   I'd l#ike to be a millionaire and spend thousands in therapy,
18       °but° .shih H °°that wouldn(h)'t work°°
19       (0.3)
20  C:   >(IT) MIGHT HELP, (.) >>but you know what I mean?
```

(1.5)
C: I ↑↑just maybe:, (2.9) >I've GOT a CONNECtion WITH THAT DOCTOR CINDY SHANAHAN. 'cuz I saw her before, on and off before, saw her privately and whatever.
(0.6)
C: °And I ↓went (yeah that's)° (.) when I talk to her I'm like nyea:h (.) but °I only see her every° three months °now=(↑anyway).°
?: ((swallow))
C: That kinda helps b#ut- it ↑needs maybe, (0.9) °say something one to one every,°
T: Ye:ah.
C: °every two to four weeks or something.°
(2.0)
C: (Spirits) °maybe one,° (1.2) five, ten, I don't know.
(1.0)
T: .Hh >DOES it fee:l- I mea:n does it fee:l helpful< °talking about stuff.°
(0.3)
C: It DOES? (0.4) it DOES, (1.5) ((movement of chair)) °uhuh.°
(0.6)
C: >IT- I:T's kind of-< (1.1) >>(more like, well)='cuz I reMEMber, (0.7) one time I was °e:h, (1.2) was it last year,°
(1.7)
C: I was talking to- >Cindy Shanahan and it was: (.) °Dr Shanahan an:d=eh,° (1.2) she goes= (>>↑why) are you=↓what's happened since last time I saw you, (0.8) °and I kind of unloaded about a lot of stuff stuff an:d, (1.7) Didn't feel good after it and then I went to the car, (.)°and I jus:t sei::zed #up.
((12 lines/90 seconds of client talk omitted))
C: I think I was: (1.0) °I dunno if it was a release or something?°
(2.0)
C: °But,° (0.8) WHAT WE'RE H↑OPing to get OUT of these th↑ings?
(.)
?: .H H
C: I don't know.
(.)
C: Not a c#ure, (.) n#o th#at's not (.) gonna h#appen.
(0.6)
C: >AS I said at the start< I w- I just want, (1.5) whether it's: having something in the back of my mind, (0.8) that I'm not saying #or, (.) whatever [or:,]
T: [Mhm.]
(1.4)

66 C: Some k- sort of tool, (0.5) or:, (.15) something to, (0.3)
67 maybe look at things differently?
68 ((10 lines/15 seconds of client talk omitted))
69 C: So I just want a:, surfboard hhh
70 T: hHm.
71 C: SOMEthing LIKE THAT, just .hh some sort of tool or whatever.
72 'Cause I know, (0.3) it's gonna happen and I'm not gonna feel
73 better.
74 (0.9)
75 C: But just when the- the wee bad times come just, (1.9)
76 T: .pch to have some way of kinda surf[ing.]
77 C: [>And the prob]lem is that
78 I'm getting worse and worse and worse.
79 ((9 lines/13 seconds of client talk omitted))
80 C: TOOLs or .hh surfboard or whatever=I don't know, I'm trying
81 to,
82 (1.7)
83 T: .Hh .pch >have you:? >so you've had some talking and in terms
84 of kind of longer term therapies, .hh or counselling=
85 C: =Ee:h well I talked to that doctor ((continues))

In line 20, the client makes an appeal to shared understanding (">(IT) MIGHT HELP, (.) >>but you know what I mean?") and thereby works to pursue agreement from the therapist. This turn marks a change in the client's positioning from developing a misaligning and disaffiliative response to the question about what might be helpful (lines 12-18) to now becoming more conciliatory and attempting to affiliate with the therapist. However, the therapist does not verbally respond to what Stivers and Rossano (2010) would categorize as a highly mobilizing appeal (">>but you know what I mean?"). Even if the therapist has produced a non-verbal acknowledgement, the therapist's refraining from verbal response shows them holding the client accountable for further expanding their turn (Muntigl & Zabala, 2008). In this absence of a verbal response from the therapist, from line 22 onwards, the client starts to substantially answer the question: "I ↑↑just maybe:, (2.9) >I've GOT a CONNECtion WITH THAT DOCTOR CINDY SHANAHAN. 'cuz...". In lines 25 and 34, there is space for the therapist to take a turn. However, they continue to refrain from doing this and thus continue to hold the client accountable for further developing their answer to the question about what might be helpful.

In line 35, the client makes a not-knowing declaration in a turn-final position with turn-final intonation and they allow a one second pause to develop. This definitively shows they have ended their turn and provides for the relevance of the therapist now taking a substantial turn. The therapist does this in lines 37-38 by posing another question, which maintains the focus on what might be therapeutically helpful: ">DOES it fee:l- I mea:n does it fee:l helpful< °talking about stuff.°" This question is a yes-no interrogative and structurally prefers a "yes" response from the client (Boyd & Heritage, 2006; Heritage et al., 2007). In line 40, the client merely agrees with this question. However, the therapist again refrains from taking the floor (line 41). This makes it relevant for the client to expand their answer. The client cooperates with this relevance by continuing to develop their answer to the question about what might be helpful by telling about their past experiences from line 42 onwards. This answer is cooperative, since the client could have alternatively dis-attended to the relevance of their continuing and instead waited for the therapist to take a turn.

The client's telling is hearably complete in lines 51-52 and also incorporates raised turn-final intonation which is usually treated as highly mobilizing of a response from the recipient (Stivers & Rossano, 2010). However, the therapist refrains from taking the floor so that a two second pause ensues (line 53) and the client re-takes the floor to re-answer the question about what might be helpful from line 54 onwards: "°But,° (0.8) WHAT WE'RE H↑OPing to get OUT of these th↑ings?(.)… >AS I said at the start< I w- I just want," (line 54…61). This turn effects a re-answering, since it re-addresses the question about what might be helpful as if it has not yet been adequately answered.

The therapist next takes a turn to formulate the client's previous talk in line 76. This highlighting formulation recycles therapeutically relevant descriptions present in the client's prior talk (Weiste & Peräkylä, 2013). The client then overlaps with the therapist to continue elaborating (lines 77-79). Finally in Extract WBRH, over three minutes after the extract starts, the therapist asks the client about their previous experience of counselling (lines 83-84). This question retains a meta-therapeutic topical focus by exploring what has been therapeutically helpful for the client in the past.

8.3.2.1 Summary & Discussion In Extract WBRH, the therapist withholds from taking the conversational floor, thus giving the client space to continue developing their misaligning and a disaffiliative response. With the therapist continuing to withhold from speaking, the client eventually begins to work towards re-affiliating with the therapist and re-aligning with the question about what might be helpful by producing an extended and substantial answer. In the extended aftermath of this answer, the therapist continues to withhold from speaking. The client cooperates with this withholding by continuing to answer the question about what might be helpful with tellings and even re-answering the question two minutes after the therapist originally posed it. After over three minutes, the therapist finally poses another question inviting further meta-therapeutic talk from the client, this time focusing on what has been therapeutically helpful for the client in the past.

In withholding from speaking and treating the client's answers as "expandable" (Muntigl & Zabala, 2008), the therapist in Extract WBRH uses what I am conceptualizing as a *liberal* dialogical style of giving the client space to respond as they like at that particular moment. We might say that the therapist further employs this liberal style by withholding from any kind of perspective display for the entire extract, which corresponds to several minutes of foregrounding the client's ideas and understandings. During this time, the therapist takes a minimal amount of turns and the turns they do take either recycle the client's prior talk, such as highlighting formulations (Weiste & Peräkylä, 2013), or are questions inviting the client's thoughts regarding the details of what they might find, and have found, therapeutically helpful. Extract WBRH is thus similar to Extract HCYDT/Part One in illustrating an instance wherein, if the therapist liberally leaves space, the client can come full circle from initially misaligning and disaffiliating with the question about what might be helpful to eventually re-aligning and providing an answer.

The client's cooperation is essential in achieving this foregrounding of their ideas in Extract WBRH. The client cooperates with the therapist by moving to expand their answer at points when it becomes apparent that the therapist is withholding from speaking. As such, the client accepts and

aligns with the therapist's withholding from speaking at this point in time. However, it is conceivable that other clients (or, indeed, the same client on a different day) might experience such an extended withholding by the therapist as persecutory or overly directive in pressuring them to continue expanding their answer. It is essential that the therapist monitors how the client is observably responding to such a withholding and perhaps also explicitly checks with the client if there is any ambiguity in how they are responding.

Extract WBRH is one of three cases of questions about what might be helpful in the current sample which are posed in the assessment session. This current case is unusual across the current sample in terms of how the client and therapist sustain such an extended stretch of talk about what might be helpful in the aftermath of a question about what might be helpful. Beyond the fact that client and therapist may be orienting to the extension of such talk as a necessary part of the business of an assessment session, it seems that this particular client and therapist are convening at a particular time when both are prepared to invest time and focus in elucidating the client's ideas regarding what might be therapeutically helpful.

8.3.3 Clinically-focused discussion

Extracts HCYDT/Part Two and WBRH differ in terms of how the therapist responds to the client's re-alignment with the question about what might be helpful. As we have seen, in Extract WBRH, the therapist uses a more liberal dialogical style by withholding from any kind of perspective display for several minutes. If the client is so-minded to cooperate, then the client's turn can be extended for longer, continuing to foreground their views and ideas regarding what might be helpful. In contrast, in Extract HCYDT/Part Two, as discussed above, the therapist's style here is one of mutuality, which involves the therapist meeting the client's perspective-display with one of their own. In putting forward a perspective-display, the therapist concomitantly de-prioritizes foregrounding and exploring the client's ideas and moves towards foregrounding and building support for their own ideas of what might be helpful for the client. At this point, we can see how a more mutual style

melds into a more pursuing style if care is not taken to liberalize or open up or de-specify the response space for the client. One possibility is that the ideal practice of pluralistic therapy necessitates a constant back-and-forth between the two poles of liberality and mutuality, of encouraging the client to respond as openly as they can, while also reserving space for the therapist to contribute. Furthermore, in a similar trajectory to the softened and de-specifying design examined in Chapter Seven, perhaps therapists would ideally de-specify or re-liberalize the response space after their contribution to prevent sliding into the more interactionally coercive style of pursuing agreement from the client. For example, by expressing "maximum curiosity" regarding any hints of preferences or ideas put forward by the client (Cooper & McLeod, 2011, p.109).

In Extracts HCYDT/Part Two and WBRH, both clients initially declare that they do not know what might be helpful. In both cases, these declarations turn out to be prefaces to more knowing responses (Beach & Metzger, 1997; Keevalik, 2011). Prefaces work to downgrade the epistemic certainty of the upcoming content, but nonetheless, they are still prefaces to a bit more knowledge. As non-answer responses, they are technically misaligning, but they can turn out "to be on their way" to alignment (Lee, 2013, p.417). These findings show the dynamic nature of alignment such that clients can be conceptualized as on the way to being more or less aligned with the meta-therapeutic agenda of sharing ideas about what might be helpful. One ongoing task for therapists is to track the client's dynamic movements in position, moment-by-moment, in the interaction. Although alignment can be considered dynamic and ongoing process, it is nonetheless an essential index of where the client is currently positioning themselves in relation to the current interactional project. The client's state of alignment shows the therapist whether the client is fully on board with the agenda of discussing ideas regarding what might be therapeutically helpful or whether they are creating some room to manoeuvre so they do not have to fully endorse it.

8.4 General discussion

This chapter investigated the aftermath of the therapist posing questions about what might be helpful. We have considered practical issues arising after clients respond by misaligning and, also, in cases after the client has aligned and offered a more substantial answer. This analysis then formed the basis for my conceptualization of three dialogical styles, which I have termed *liberal*, *mutual* and *pursuing*. We conceptualized the possibility that the practice of pluralistic therapy may necessitate ongoing movement between the two poles of liberality and mutuality, alongside a constant vigilance against unreflectively sliding into a pursuing style. As outlined in the Chapter Two, concepts like dialogue and collaboration have not previously been described in sufficient interactional detail. Following Howard, Nance and Myers (1987), Cooper and McLeod (2011) do specify that therapists may need to change their "relationship repertoire" (p.53), for example, between supportiveness and directiveness, but this point does not concretely specify how clients and therapists can actually engage in dialogue *per se*. The analyses in the current chapter therefore contribute towards interactionally specifying the complexity of applying this mandate in practice. Making this complexity more explicit can lead to more informed practitioners and refinement of training practices, since training can then move beyond discussing broadscale concepts like *dialogue* and *mutual*ly *sharing ideas*. For example, in the current chapter, we have described several interactional features, which therapists could usefully develop sensitivity to, including: how the therapist might use a topic shift to manage the client's misalignment, the interactional features of pursuit, whether or not – and precisely how – the therapist follows up the client's ideas with ideas of their own, and possible kinds of response spaces for the client after the therapist has presented their ideas.

The current conceptualization of dialogue as comprising continuous movement between two opposing poles seems necessary if its implementation is to encompass both a respect for the client's voice and existing resources, strengths, skills and knowledge about what might be helpful, as well as space for the therapist to contribute their skills and expertise. In addition, this conceptualization of dialogue coheres with the dilemma discussed in Chapter Seven regarding how

the therapist's shift towards creating opportunities for meta-therapeutic dialogue can actually come off as less than mutual if substantial relational work is not invested to prepare the ground so for the client to take up the opportunity. We considered how this preparatory work must move between the opposing poles of supportively scaffolding and *pursuing* an answer from the client while more *liberally* not presuming that they will do so.

The current findings and conclusions cohere with existing conceptions of collaboration as moving between two opposing positions, such as more *supportive* and more *challenging* interventions (Ribeiro et al., 2013a), dialogue as balancing between *validation* and *confrontation* (Linehan, 1993 as cited in Sutherland, Turner & Dienhart, 2013) and even disagreement being done by the therapist in more or less supportive ways (Weiste, 2015). Furthermore, linking in with previous CA findings, Voutilainen, Peräkylä and Ruusuvuori (2010b) distinguished between the therapist's empathic *recognition* of the client's emotional stance and their *interpretation* of the client's stance, which adds new meaning to the client's talk. Voutilainen and Peräkylä (2016) subsequently conceptualized their 2010 study as demonstrable evidence for *empathy* and *challenge* in the client's work. My notion of a *liberal* style is similar to therapist actions that empathize with, and thus, validate the client's position, while the *mutual* and *pursuing* styles might be roughly equated confrontation or with being challenging.

Similarly to Voutilainen and Peräkylä's conceptualizations of *empathy* and *challenge* and in contrast with the other studies mentioned above, my conceptualizations of dialogue have been derived from data-driven analyses of what the client and therapist have themselves been treating as important in the interaction. For example, what I term the *liberal* style describes the therapist giving the client plenty of affiliative, interactional space to develop their turn; the *mutual* style describes the therapist giving their view in response to the client's; the *pursuing* style describes publicly available aspects of the therapist's perspective-display which pursue a certain kind of response from the client. These conceptualizations can thereby be related back to the priorities displayed by

participants while carrying out the interaction, which locates them at just one remove from therapists' concrete actions.

My conceptualization adds to Voutilainen and Peräkylä's by extending their focus from emotional stance to more consider how the therapist can validate the client's contributions to alliance-focused discussions and how the therapist can attempt to more mutually contribute to these discussions themselves. Furthermore, my conceptualization centres on the notion of opportunities or space for one or both participants' contributions, which links it more firmly with the therapeutic ethic or SIK of *dialogue* as discussed in Chapters Two and Five. Thus, again, my conceptualization potentially applies to all instances of sharing and contributions by clients and therapists, including alliance-focused and adult-to-adult ones, whereas Voutilainen and Peräkylä's empathy/challenging conceptualization was developed within cognitive and psychoanalytic therapies, wherein the therapist is considered to be more expert and less emphasis is placed on mutuality. Finally, my findings also extend and specify the SIKs of *dialogue* and *challenge* by distinguishing between *mutual* and *pursuing* styles. The therapist's co-construction is considered an essential part of dialogue, but that this co-construction can quickly turn into a more *pursuing* style, which becomes less about cooperating in an interactionally un-coerced manner and more about convincing the client or securing alignment. Of course a *pursuing* style can have its uses if the therapist judges that it is not beneficial to desist from a meta-therapeutic agenda at this point. However, the risk is that a pursuing style leaves little interactional space to consider why the client might be avoiding or resisting aligning with this agenda at this point.

Conceptually, the descriptions of dialogical styles can be considered intermediary SIKs, practically useful in bridging the gap between broadscale notions like *dialogue* and therapists' concrete actions (Peräkylä & Vehviläinen, 2003). The conceptualizations of dialogical styles are less specifically referential than descriptions of therapists' concrete actions. In this sense, the conceptualization of styles can be considered at a slightly broader, less concrete conceptual level

than descriptions of concrete actions which form the basis for CA findings. Table 8.1 illustrates the conceptual levels I am assuming during this discussion.

Table 8.1: Conceptual levels assumed in discussions of dialogical styles

General theoretical concept	**dialogue**					
Intermediate SIK e.g. dialogical style	**liberal**		**mutual**		**pursuing**	
Therapists' concrete actions, described by CA e.g.	**agree**	**question**	**suggest**	**overlap**	**withhold from speaking**	**etc.**

8.4.1. Future research

A recurring theme in the current chapter concerns the issue of what to leave implicit or to make explicit regarding the client's varying degrees of alignment with the agenda of talking about what might be helpful. Findings illustrate how, in cases of client misalignment, one trajectory utilized is for both participants to move to talking about issues outside the therapy room, and thus, not to pursue a meta-therapeutic discussion for now. One associated consequence of this move is that the causes or sources of the client's misalignment are also not explicitly discussed. Indeed, there are no such cases of explicit discussion of the client's misalignment with the therapist's question about what might be helpful in the current sample. We have already outlined the various advantages of having such discussions in previous sections of this chapter. It may be relationally and epistemically safer in the short-term to avoid such discussions, but, as the research on the alliance ruptures and repairs indicates, meta-communicative discussions improve outcomes in the long term (e.g. Safran & Muran, 2000). Indeed, the developers of pluralistic therapy also advocate addressing ruptures as an essential relational "maintenance" task for pluralistic therapists (Cooper & McLeod, 2011, p.85). The question arises as to why there were no such explicit discussions in the current sample. One reason might be the small sample investigated by the current study. However, other possible reasons merit further observational studies, especially since Jager et al. (2016) and Oddli et al. (2012, 2014) also

found a very small number of explicit discussions in their collections of therapeutic interactions. It might therefore be that there is something inherently interactionally challenging about undertaking such explicit discussions even if this is mandated by professional SIKs. Muntigl and Horvarth (2014) have examined how therapists move to implicitly repair interactional ruptures and Voutilainen, Peräkylä and Ruusuvuori (2010a) explicated a case in which the therapist moved to explicitly discuss the rupture. However, there is still a need for research on how other therapists might explicitly address such ruptures and the factors involved in making such explicit addressing so infrequent.

8.4.2 Limitations

The conceptualization of dialogical styles I have developed from the current analysis can potentially be subjected to the same criticisms I have made of deductively-derived coding systems (cf. Chapters One and Two). This criticism is that the notion of dialogue constitutes a theoretically-derived category which I have then been imposing on the interactions. However, I developed the conceptualization after conducting a CA study on the aftermath of questions about what might be helpful. As such, the CA findings (reported first in each empirical section of the current chapter) still hold, regardless of the subsequent conceptualization which I have related to them. Indeed, the CA findings comprise inherently more accurate and comprehensive descriptions of the interactions, and they focus on what participants themselves are treating as important in carrying out the interaction. In contrast, the conceptualization of dialogical styles is potentially motivated by practical concerns external to participants' interests in the interaction. As discussed throughout this chapter, I developed this conceptualization as a conceptual intermediary between CA findings regarding the concrete interactions and the theoretical ideal of dialogue. My suggestion is that such an intermediary can serve as a practical innovation in linking the notion of dialogical to participants' concrete actions. However, this intermediary cannot substitute for descriptions of participants' concrete actions provided by the CA findings.

Finally, the current conceptualization of dialogical styles is suggestive and indicative only and it does not comprise systematic descriptions or codes encompassing the entirety of the current sample. Thus, rather than systematically presenting implications, the current chapter can only raise reflective questions rather than generally conclusions concerning the concrete practice of pluralistic therapy.

8.4.3 Links with existing CA research

The current findings build on previous CA studies regarding how therapists manage *not-knowing* and other misaligning responses from clients. Similarly to the current findings, MacMartin (2008) found that most common way therapists dealt with clients' misaligning responses to optimistic *wh*-questions was to reissue or recycle the problematic question with some adjustments to facilitate the client to align. Jager et al. (2016) investigated Dialectical Behaviour Therapy and found a diversity of ways in which therapists responded to clients' *not-knowing* responses, ranging from *redoing the question* to *proposing a candidate answer* to *guiding the client to an answer* and *meta-talk*. Jager et al. similarly found that explicit discussion regarding the client's misaligning answer (i.e. what the authors termed *meta-talk*) was rare in their sample (occurring 3 times out of a total of 77 instances). They also found that quite frequently therapists moved to a different topic in the face of the client's misaligning responses. These similar findings highlight the difficult interactional task which it appears to be for therapists to explicitly address clients' misaligning responses. The current findings contribute by elucidating another practice therapists can use for managing clients' *not-knowing* responses which is to *liberally* and affiliatively make space for the client to further develop their response. As discussed above, this practice shares some similarities with Muntigl et al.'s (2013) descriptions of *active retreating*, but the interactional contexts in which these occur are distinct.

The current findings also hint at the possibility that therapists might responsively adjust how they pose the subsequent questions about what might be helpful after the client has misaligned with the first question – even if this subsequent posing occurs a substantial time later in the session

(cf. Section 8.2.4.2). Evidencing this possibility would require a CA study which extended beyond one-off extracts seconds or minutes long to one which traced interventions across whole sessions – and perhaps even across multiple sessions. This is a growing focus in CA research on psychotherapy (e.g. Bercelli, Rossano & Viaro, 2013; Voutilainen, Peräkylä & Ruusuvuori, 2011) and the current findings require further research to substantiate the hint they have highlighted.

Chapter 9: Discussion

9.1 Summaries and reflections

9.1.1 Practice-relevant findings The primary aim of the current project research project was to use the discovery-oriented, observational method of CA to investigate how pluralistic therapists and clients engaged in meta-therapeutic talk with respect to therapeutic methods. I anticipated that such an investigation would contribute towards addressing the research-practice gap in this area by developing some findings with clear relevance for practice.

The project fulfilled this aim by gaining access to a relevant data corpus and developing the thematic code, *talk about what might be helpful*, to identify cases potentially relevant for investigation. I then focused in-depth on therapists' questions to clients about what might be therapeutically helpful as one means in which therapists might facilitate opportunities for clients to collaboratively and dialogically participate in meta-therapeutic discussions about methods. As discussed in Chapter Five, even just the selection process for building a collection of such cases resulted in multiple practice-relevant observations. In Chapters Six through Eight, I then explored the context, design and aftermath of this collection of questions. This investigation has formed the basis for a substantial number of observations with implications for practice, summarized in Table 9.1. These findings are subject to the limitations which I have discussed throughout the thesis and which are summarized and reflected on once more in Section 9.1.4. I also identified some conceptual distinctions pertinent for the ongoing development of pluralistic therapy and areas for future research, which I will summarize and discuss in Sections 9.1.2 and 9.1.5 respectively .

As discussed in Chapters One and Three, I consider the findings, summarized in Table 9.1, to be *practice-relevant* since they remain close to how therapists and clients actually carry out meta-therapeutic dialogue by describing their concrete actions. These descriptions of concrete actions predominantly highlight aspects which appear key to the achievement of meta-therapeutic dialogue and, consequently, are highly pertinent for therapists to reflect upon. Occasionally, the descriptions

culminate in suggestions for possibly beneficial actions for pluralistic therapists to engage in. However, these suggestions are subject to the limitations summarized in Section 9.1.4.

The practice-relevant observations in Table 9.1 are quite specific to the particular scenarios analysed, but they also highlight some reoccurring issues across cases and contexts. I have grouped them into the themes of *Creating or opening an opportunity for meta-therapeutic dialogue*, *Design of questions about what might be helpful*, *Pursuing answers from clients* and *Client misalignment and the current state of explicit discussion/meta-communication*. As indicated in Table 9.1, these themes roughly breakdown according to the foci in Chapters Six through Eight. However, the observations from Chapter Five tend to be spread across these themes, since this chapter, in effect, gave a broad overview of analytic and practical issues pertaining to questions about what might be helpful as a form of meta-therapeutic dialogue.

Table 9.1: Summary of practice-relevant findings
* Thesis section(s) in which findings are summarized and discussed.

Practice-relevant findings	***Section****
Creating or opening an opportunity for meta-therapeutic dialogue	
Clients can equivocally refer to hoped-for states of affairs, which is complex for therapists to respond to due to the mix of goal-relevant and troubles-telling material. This is a challenging environment in which to open an opportunity for meta-therapeutic dialogue.	6.2.4.1
Pluralistic therapists need to judge which therapeutic relevancy (e.g. empathic, problem-solving) to prioritize at any point and whether they could attend to more than one at a time.	6.2.4.2, 6.4
Substantial relational work may be at times required to secure the client's alignment to even just initially shift to a meta-therapeutic framework.	6.2.4.2
Paradox for pluralistic practice: meta-therapeutic dialogue may not be mutual if the therapist is advancing it and the client is not fully aligned as to the timing and need for it.	6.2.4.3
Therapists' questions about what might be helpful create an opportunity for meta-therapeutic dialogue, but they can also be treated as problematic by clients on a number of levels i.e. potentially face-threatening, testing, creating role ambiguities.	6.2.4.4
Therapists' questions about what might be helpful can work to substantially involve clients in a new activity after they have been minimally participating regarding the previous topic.	6.3.3

Therapists may pose these ostensibly dialogical questions as a new topic to avoid investigating cases of reticence and possible disagreement by the client.	6.3.3
Design of questions about what might be helpful	
Importance, for a resource-oriented approach, of distinction between inviting client's own ideas and inviting their views on therapists' ideas.	5.7.2
More specific questions about what might be helpful foreground goals, problems and solutions beyond the therapy room, and so, de-emphasize a focus on therapeutic process.	5.7.2
Through crosscutting question designs, therapists project that posing questions about what might be helpful is not a straightforward matter.	7.2.3
Clients initially treated therapists' minimally softened *wh*-questions as problematic, showing a mismatch regarding what the client should be expected to know.	7.2.3
The context in which the therapist poses a minimally softened question may compound this mismatch between expectations e.g. if posing the question at a particular juncture involves de-prioritizing empathic and affiliative relevancies or is face-threatening. Minimally softened questions at such junctions may work outside the client's *therapeutic zone of proximal development*.	7.2.3
This substantially softened design addresses some of the relational difficulties arising with the minimally softened design, since the therapist prepares the ground for the question and thereby lessens the possibility of the client misaligning. In general, the more understanding and affiliation therapists displayed in the design, the more aligned clients were when responding.	7.3.3
Therapists should be aware that when they end their question turn with a suggestion, this de-emphasizes the relevance of clients dialogically contributing their own ideas.	5.7.2, 7.3.3
By using a softened and de-specifying question design, therapists can balance between supportively scaffolding the client to answer while still making a clear space for them to independently contribute ideas about what might be helpful.	7.4.3
Therapists may have individual styles when posing questions about what might be helpful, so it might be useful for them to learn about possible other question designs.	7.6.1
Pursuing answers from clients	
Some questions can *appear* dialogical but actually come close to being interactionally coercive.	5.7.2
CA-based materials can be used as reflective prompts for practitioners e.g. why might a therapist pursue an answer from a client to the point of interactional coercion?	5.7.2
A meta-therapeutic dilemma for the pluralistic therapist concerns whether to pursue an answer to a question about what might be helpful or whether to leave space for the client to fully develop a misaligning response which may challenge the question agenda.	8.2.4.1
Therapists should be fully aware of the pursuing nature of some of their interventions.	8.3.1.1
Therapists could de-specify or re-liberalize the response space after their own contribution to prevent sliding into the more interactionally coercive style of pursuing agreement from the client.	8.3.3
Client misalignment and the current state of explicit discussion/meta-communication	

It is possible for clients to participate in talk about what might be helpful while still refraining from fully endorsing the usefulness of such talk i.e. thereby engaging in various forms of implicit interactional resistance or misalignment. Therapists should be sensitive to this and, perhaps, explicitly investigate with clients.	8.2.4.2, 8.3.1.1, 8.3.21, 8.3.3
One way of managing clients' misaligning responses is to shift away from meta-therapeutic talk to talk about experiences or issues outside the therapy room. This represents a safer relational and epistemic ground but also precludes explicit discussion of the misalignment.	8.3.1.1

The findings in Table 9.1 have already been comprehensively discussed in the foregoing chapters, so rather than repeating these discussions, I will now report some general observations, before moving on in the rest of this chapter to make some final comments in relation to conceptual distinctions, limitations and areas for future research.

These findings also inform other conceptually-related therapeutic approaches, discussed in Chapter Two, which advocate the use of collaboration, dialogue, shared decision-making and resource-oriented interventions. For example, the findings expand on Strong and Sutherland's (2007) conceptualization of dialogue by comprehensively demonstrating how therapists can explicitly invite clients to participate in co-constructing therapeutic methods. The findings also contribute towards addressing an underlying tension in meta-therapeutic talk and conceptually-related areas, namely, how to bring *both* client and therapist expertise into dialogue, given possible phenomena like client deference (e.g. Rennie, 1994). Similarly to CA studies in other mental healthcare settings (e.g. Thompson, 2013), the current project has demonstrated how clients can resist the responsibility to answer questions about what might be helpful, thus showing a mismatch as to what the client should be expected to know. This again highlights the possibility that initiatives such as shared decision-making and meta-therapeutic dialogue are initially incompatible with pre-existing social realities, such as asymmetrical professional and client roles. However, the current findings further contribute to this practical puzzle by showing how therapists can start to work to make these initiatives more locally compatible by observably attending to such asymmetries, so that clients will more readily align and participate. For instance, Chapter Seven shows how therapists can

balance between supportively scaffolding the client to align with and answer questions about what might be helpful, while still also clearly demarcating the relevance of the client giving their own ideas. Chapter Eight also provides a conceptualization of how the expertise of both clients and therapists can be foregrounded through the therapist's movements between liberal and mutual dialogical styles.

An overall practice-relevant finding relates to the difference between interaction-far and interaction-near observations of what therapists are doing. For example, as illustrated in Chapter Eight, from an interaction-far perspective, clients' ambiguous alignment with the question about what might be helpful can appear as full participation and the therapists' mitigated pursuit can appear hesitant and non-coercive (cf. Section 8.3). However, the turn-by-turn, granular Conversation Analysis shows the complex, multi-faceted nature of participants' actions. Without this level of analysis, there is a risk that conceptualizations of the practice of pluralistic therapy (and other forms of collaborative working in therapeutic contexts) will be simplified and idealized – which is unhelpful for supporting practitioners, developing training and producing practice-relevant research in future.

A reoccurring theme in these practice-relevant findings is the interactional dilemmas which observably and recurrently arise in the course of meta-therapeutic dialogue and the ways in which participants managed these dilemmas. This focus on dilemmas was partially motivated by my research aim of foregrounding analyses which demonstrated straightforward relevance for practice. But the indications of dilemmas in the findings, reoccurring across client-therapist pairs, also speaks to the challenges facing therapists – of managing local, interactional contingencies with particular clients while still also getting therapeutic business done as mandated by the specific therapeutic approach. As such, these findings provide a substantial level of insight into how participants actually carry out the interactions, moment-by-moment, which I, for the purposes of the current project, have glossed as meta-therapeutic dialogue.

9.1.2 Conceptual contributions to existing SIKs

A further aim of the current project was to relate the analytic findings to existing guidelines or descriptions regarding the practice of meta-therapeutic dialogue about methods (cf. Chapter One, section 1.4.1). As discussed in Chapter Three, these existing descriptions can be considered stocks of interactional knowledge (SIKs), which are made available to professionals to guide their practice (Peräkylä & Vehviläinen, 2003). As well as findings with the immediate practical implications discussed in Section 9.1.1, the current investigation has thrown up some conceptual distinctions, which I have discussed as they arose across the thesis. These conceptual distinctions engage with existing SIKs in the pluralistic therapy literature. They therefore raise some discussion points for the ongoing practical and conceptual development of pluralistic, collaborative and dialogical approaches.

9.1.2.1 Formal and informal opportunities In Chapters Two and Four, I distinguished between formal opportunities (i.e. using personalization tools) and informal opportunities for engaging in meta-therapeutic dialogue with respect to methods. This distinction has not previously been emphasized in the literature. It opens up a conceptual space regarding the different flavours of dialogue that these different kinds of opportunity might engender. Furthermore, the use of how informal opportunities might be necessary to fully dialogically advance a resource-oriented approach, which explores and endorses clients' idiosyncratic strengths.

9.1.2.2 Meta-therapeutic dialogue as essentially a problem-solving or solution-focused activity At several points in this thesis, I discussed the conceptual differences between meta-therapeutic dialogue with respect to methods in pluralistic therapy and other therapeutic problem-solving (e.g. CBT) or solution-focused approaches (e.g. SFBT). In particular, in Chapter Five, I elucidated how some talk about what might be helpful might essentially be considered a problem-solving or solution-focused approach, particularly if it is specifically focused on a working on a particular issue

or goal external to the therapy sessions. I also discussed how questions which are more broadly process-focused on various available therapeutic approaches, activities and ways of using the therapy sessions could be considered more quintessentially pluralistic and meta-therapeutic. This is since these questions aim to collaboratively discuss both the helpfulness of the therapy in itself as well as considering the array of helpful approaches which could be utilized. Such discussions of the helpfulness of the therapy itself show the emphasis on alliance-building in pluralistic therapy, while a focus on the range of possible helpful approaches corresponds to technical eclecticism, another hallmark of pluralistic therapy.

The more process-focused questions were much less frequent in the current collection and Papayianni and Cooper (2017) also included talk about extra-therapeutic activities as part of their definition of meta-therapeutic dialogue. Participants also treated both types of question about what might be helpful similarly (e.g. Chapter Six, section 6.4). Thus I took the decision to also include the more specific, problem-solving/solution-focused questions in the current collection. This finding leads to the possibility that *all* meta-therapeutic dialogue, including that which is process-focused and that which more specifically-focused, can be considered a species of problem-solving or solution-focused approach. This is particularly conceptually plausible since meta-therapeutic talk about methods assumes the existence of therapeutic goals, and we could argue that goal-focused activities are inherently problem-solving/solution-focused.

So what might the implications for existing SIKs regarding meta-therapeutic dialogue, if we accept these conceptual arguments and observational evidence that meta-therapeutic dialogue might be considered a form of problem-solving? On the one hand, this equation with problem-solving could benefit the development and practice of meta-therapeutic dialogue, since practitioners and trainers could more knowingly draw upon existing resources for such practices, for example, from SFBT and motivational interviewing (Miller & Rollnick, 2002). Furthermore, it might help to demystify the practice of meta-therapeutic dialogue and make it more concrete for practitioners and clients to understand and engage with. However, on the flipside, it can be argued

that equating meta-therapeutic dialogue with other problem-solving activities could risk occluding the ethical and relational connotations relating to meta-therapeutic dialogue *qua* dialogue. Furthermore, Papayianni and Cooper (2017) give the impression that the focus of meta-therapeutic talk can extend beyond specific problems to focus on the client's experiences of helpful or unhelpful therapeutic processes. Indeed, Cooper and McLeod (2011) talk about creating a *culture of feedback*, which seems a lot less focused than conceptualizations of meta-therapeutic dialogue as problem-solving talk concerning the client's goals and how they can reach them, including how the therapy sessions can help. However, the rejoinder again is that less specific, vague concepts remain far-removed from practice and thus more difficult to concretely conceptualize and implement. My hope is that the back-and-forth discussion presented in the current thesis can fruitfully contribute to the extension or adjustment or elaboration of SIKs pertaining to meta-therapeutic dialogue, most specifically regarding methods.

9.1.2.3 Dialogical styles as an intermediary between theory and practice In Chapter Eight, I used Conversation Analytic findings to extend existing SIKs regarding dialogue by suggesting some possible intermediaries, namely the differing dialogical styles of *liberal*, *mutual* and *pursuing*. This suggestion of intermediary SIKs attempted to conceptually bridge the gap between broadscale, theoretically-derived SIKs concerning dialogue and participants' concrete actions in pluralistic therapy sessions.

This intermediary conceptualization of dialogical styles depicts the concrete practice of dialogue as a constant balancing between two opposing poles of liberality and mutuality. The liberality pole, wherein the therapist affiliatively supports and endorses the client's development of both aligning and misaligning responses, is considered necessary to encourage the client's contribution in the context of asymmetrical expert-therapist and in-expert client roles. The mutuality pole is also necessary to ensure the therapist shares their views, thus rendering the therapy a mutual endeavour rather than one in which the client's stated preferences are

monologically fulfilled without also discussing and/or integrating the therapist's perspective. Actions by therapists, which we would characterize as mutual, then have the potential to quickly develop into a pursuing style, which works to secure the client's alignment with the therapist's intervention or perspective. The *softened-and-de-specifying* question design in Chapter Seven is paradigmatic of the kind of back-and-forth movement which might ideally be required between these styles.

These intermediary conceptualizations of dialogue can also be related to considerations of power in the therapeutic relationship – in particular, the short and quick slide from *mutual* to *pursuing* styles on the part of the therapist. Being mutual is a necessary in order to create dialogue and, in some cases, there might be a need to also incorporate a pursuing style, but the latter would ideally be done sparingly and with full awareness of its interactionally coercive potential (cf. Chapter Five, section 5.5.4 and Chapter Eight, section 8.3.1). These considerations are all the more relevant given that the therapist's pursuit of the client's alignment might be more potent in the context of asymmetrical roles and client deference. This might not be the case in all contexts and for all clients, but the possibility is something to guard against by therapists being aware of what pursuit looks like interactionally and trying to limit their usage of it. There is also a need to ensure that therapist's pursuit of client's alignment (e.g. with solution slots, cf. Chapter 5) does not result in reducing meta-therapeutic dialogue to a tick-box exercise in securing the client's alignment with the approach the therapist thinks is best.

Finally, amidst these conceptual musings regarding meta-therapeutic dialogue, it is ethically essential to constantly hold an awareness of wider socio-political realities (Evans, 2012). Even if a therapist and client manage to consistently achieve meta-therapeutic dialogue throughout the therapy, this facilitation of client autonomy may be of severely limited benefit if their autonomy and rights are permanently impeded by structural inequalities in wider society, such as racism, sexism and poverty. There is a danger that the notion of meta-therapeutic dialogue, operating as it does with an individualistic model of therapy and claiming to facilitate client autonomy, is actually then implicitly locating the causes of distress within the client rather than also highlighting and addressing

underlying social and structural inequalities (Vermes, 2017). Unfortunately, the current thesis has engaged in no substantial interrogation of how the notion of meta-therapeutic dialogue might reinforce or challenge existing socio-political realities. However, Vermes has begun such a project and perhaps others, such as myself, will now begin to follow suit.

9.1.3 Rendering interaction-near CA findings practice-relevant

My engagement with SIKs concerning meta-therapeutic dialogue, summarized in the last section, 9.1.2, also highlights some methodological and presentational considerations, which I have tried to implement in this thesis. These considerations involved keeping the Conversation Analysis of selected cases separate from more conceptual and practically-motivated issues in selecting the data and considering clinical implications. I have endeavoured to clearly preserve this distinction, particularly in Chapters Four and Five, wherein I selected the data using theoretical categories like *dialogue* and *therapeutic methods* and the thematic code of *talk about what might be helpful*, and in Chapter Eight, wherein I derived a theoretically-informed conceptualization from the CA findings. Throughout Chapters Five through Eight, I have also taken care to discuss clinical implications and issues separately from the sections in which I presented the Conversation Analysis proper.

I argued in Chapter Three that this innovation in presenting the CA findings renders them more accessible to psychotherapy researchers and practitioners, while still also adhering to the analytic boundaries essential for conducting a *bona fide*, discovery-oriented CA investigation. My thesis demonstrates the substantial work required to build this bridge between CA findings and implications for practice. As discussed in Chapter Three, the CA findings are indeed practice-near, but they are practitioner-far in that they are often considered to be intractable to non-CA researchers and practitioners. Engaging with SIKs and suggesting elaborations or extensions or corrections is a substantial task, which is distinct from doing CA proper (Peräkylä & Vehviläinen, 2003). However, this task is necessary if CA findings are to usefully inform therapeutic practice.

As discussed in Chapter Three, this task of rendering the practice-near findings of CA practitioner-near or accessible requires researchers who have knowledge of both CA and with therapeutic SIKs. This is since researchers need to be aware of and sensitive to the therapeutic relevancies oriented to by participants, while still also being able to take an action-orientation to the data and to articulate what the participants themselves are observably treating as important as they are carrying out the interaction (Leudar et al., 2008). However, my thesis also demonstrates how this rendering process is far from straightforward. For example, in conducting the current project, for a substantial time, I was subjectively aware of a gulf between the CA findings and how to articulate their relevance to practice. This gulf appears to be a central paradox of this project. On the one hand, the project promises practice-relevant and clinically relevant findings derived from a methodology which is inherently practice-based, and yet, on the other, rendering these findings accessible to practitioners is a substantial piece of work itself. Perhaps this paradox stems, at least partially, from the nature of how we talk about and conceptualize therapeutic practice compared to the interactional complexity of which it is actually comprised (Schön, 1987).

Another possible contributing factor to my experiencing an apparent gulf between CA findings and therapeutic practice is that, despite my best efforts, I have conducted the CA studies and presented the findings in an overly dense or complex manner. For example, perhaps, as Billig (2013) recommends, I could have endeavoured to use less technical language and to keep my descriptions of the interactions briefer and more actor-focused. Nevertheless, at least I have presented the analyses transparently enough so that the reader can investigate evidence for this and others criticisms.

Despite these difficulties connected with the innovative presentation I have attempted in this thesis, I contend it still represents an advance in working to reduce the research-practice gap and render the practice-near focus of CA accessible for practitioners. This advance comprises the concerted effort to explicitly relate a broad SIK like meta-therapeutic dialogue to participants' concrete actions in therapy sessions. My efforts to achieve this specific relation have involved efforts

to conceptually clarify what it consists of and also the practical innovation in terms of presenting clinical implications separately and more frequently than is usual. As discussed above, I do not think these efforts have completely diminished the gap between CA's practice-based focus and accessibility and relevance for practitioners, but they do provide an explicit basis upon which to build.

9.1.4 Limitations

Table 9.2: Summary of limitations
* Thesis section(s) in which findings are summarized and discussed.

Limitations	***Section ****
A limited number of sessions were sampled.	5.7.3
Sessions and cases from one qualified therapist were over-sampled relative to the number of other participants.	5.73, 6.4.1
Possible arbitrariness in selection criteria for questions about what might be helpful.	5.7.3
Overly narrow definition of dialogue utilized i.e. focusing on one-off cases of questions as opposed investigating an ongoing process over longer stretches of talk.	5.7.3
Focus on explicit instances of meta-therapeutic talk entails a de-emphasis on possible implicit instances.	5.7.3
Only illustrated two prior contexts for questions about what might be helpful and also, just the immediate prior context instead of the whole session before the question.	6.4.1
Aside from individually considering the specific, local context of each case, no systematic comparison of contextual features and designs across cases and pairs.	7.6.2
Conceptualization of dialogical styles is suggestive only and does not comprise systematic descriptions or codes encompassing the entirety of the current sample.	8.4.2

Table 9.2 contains a summary of limitations of the current project, which have been discussed in the individual chapters indicated. In what follows, I will briefly indicate which limitations I consider to be the most impactful on the current findings.

First, I did not systematically analyse all cases in the current collection with respect to all of my analytic foci of interest. Chapter Seven is the exception to this, but the analyses in Chapters Four, Six and Eight are indicative of a few cases only, rather than exhaustive analyses which describe the

whole of the current collection. This means that the analytic evidence for the implications drawn in these chapters is not as strong as it could be if I had based it on all 28 cases in the current collection.

Second, the current study has focused in-depth on what I have been considering one form of opportunity for meta-therapeutic dialogue, namely therapists' questions to clients regarding what might be helpful. However, as briefly indicated by Chapter Four, there are numerous other ways in which such opportunities could be created by clients and therapists. Thus focusing on just one form of opportunity limits the scope of the current implications for practicing meta-therapeutic dialogue. I outlined the rationale for selecting such an in-depth focus in Chapter Five. Related to the narrow focus of the current study, I also did not conduct a systematic, quantitative survey of talk about what might be helpful. Such a survey potentially would have substantiated my anecdotal claims (cf. Chapter Four) that suggestions by therapists were the most frequent means of initiating opportunities for meta-therapeutic dialogue.

Third, as discussed in Chapter Five (5.7.3), another possible criticism which can be levied against the current study is that I have focused predominantly on specific one-off actions and have thus neglected to treat meta-therapeutic dialogue in its full sense as an ongoing, dynamic process. Chapter Eight attends to this ongoing, dynamic nature to some degree, but there is certainly scope for further discovery-oriented, observational research of meta-therapeutic dialogue as an ongoing process within and across sessions. Furthermore, Doran et al. (2016) noted how scores of alliance negotiation were higher for therapeutic dyads who had been working together for a longer period of time, and who met more regularly. As such, it is possible that an observational study which focuses more on sampling extracts in accordance with the number of sessions therapists and clients have had to develop the therapeutic relationship may identify different ways of doing meta-therapeutic dialogue as the relationship develops.

9.1.5 Areas for future research

Table 9.3: Summary of areas for future research
* Thesis section(s) in which findings are summarized and discussed.

Areas for future research	***Section****
Investigate the possibility that some talk which is not meta-therapeutic might still be considered *pre*-meta-therapeutic talk i.e. as a precursor or leading to such talk.	4.5
Further investigation of formal opportunities for personalization i.e. of participants' use of preferences forms, with a focus on more and less dialogical ways of using these.	2.6.1., 4.5
Investigate talk about what *has been* helpful as a means of facilitating feasible and sustainable transitions to talk about therapeutic methods.	4.5
Develop a taxonomic, quantitative survey of different instances of meta-therapeutic talk to establish the relative frequency of such talk across therapist-client pairs and whether there is a relationship between the frequency of such talk and therapeutic outcomes.	4.5
Variation in therapists' interventions may show responsiveness to each individual client and might potentially constitute an adherence measure for pluralistic therapy.	5.7.1
Would an increased number of more process-focused questions about what might be helpful contribute to an improved therapeutic alliance and overall therapeutic outcomes?	5.7.2, 6.4.2
Further investigate clients' equivocal references to hoped-for states of affairs i.e. to assist therapists in responding, and to investigate links with existing research on client ambivalence and as possible gateways to alliance formation.	6.4.2
Develop guidelines for how pluralistic therapists might manage multiple posings, in the same session, of questions about what might be helpful if the client has initially misaligned.	8.2.4.2
Investigate how therapists might explicitly discuss misalignments by the client (i.e. meta-communication) and any interactional factors contributing to the current apparent infrequency of such discussions.	8.4.1
Investigation of possible explicit and implicit factors in how therapists' dialogical styles differ across different clients.	8.2.4.2

This project has suggested a substantial number of areas for future research regarding the practice of meta-therapeutic dialogue with respect to methods. These are summarized in Table 9.3 with references to the sections of the thesis in which they were originally discussed. I will now discuss two areas for future work which have not yet been discussed in detail in the thesis. The first area concerns CA-based training modules for therapists and the second concerns the development of adherence measures for meta-therapeutic dialogue and pluralistic therapy.

The current findings document how therapists and clients go about one aspect of meta-therapeutic dialogue at the tacit, procedural, pre-reflective level of interaction (Madill, 2015; Hepburn, Wilkinson & Butler, 2014; Peräkylä, 2011; Polkinghorne, 1999). As such, the practices identified may not be something that therapists can immediately or easily consciously adjust. As anticipated in Chapter Three, it may therefore be that the immediate clinical usefulness of the current findings will be in providing training material to facilitate reflection on different real-world approaches to meta-therapeutic and similar forms of talk. For example, trainees could uses these training materials, derived from real-world therapeutic contexts, to articulate the contextual considerations and relative advantages and disadvantages of the different ways of posing questions to clients regarding what might be therapeutically helpful. Such training could draw on existing models for developing training materials from Conversation Analytic findings (e.g. Stokoe, 2014; Strong, 2003). Such training could increase trainees' awareness of previously unnoticed, tacit features of therapeutic interactions, which should then enable them to respond more deliberately in real-world therapeutic contexts (Cantwell et al., 2017, May; Fitzgerald, 2013; Polkinghorne, 1999; Schön, 1987). This training could also incorporate skills-and-drills exercises so that trainees can obtain some concrete practice of what it is like to manage particular interactional dilemmas. In addition, the 'drills' component of these exercises might enable therapists to integrate some of the more tacit features, which are useful in managing these demands, into their own practices (Cantwell et al., 2017, May). However, as it stands, these training possibilities require piloting and investigation as to their effectiveness.

The current findings show how questions about what might be helpful are one site at which therapists visibly adhere to the recommendations for creating opportunities for meta-therapeutic dialogue – and thus, for doing pluralistic therapy. These questions are therefore one set of actions which could be included in an adherence measure for pluralistic therapy. Given their relatively infrequent occurrence, such questions would not be sufficient in themselves as a measure of adherence. However, the findings from this thesis show that they would be one valuable indicator of

adherence. Furthermore, as discussed in Chapter Five (Section 5.7.1), variation in whether and how often therapists initiate meta-therapeutic dialogue may also show responsiveness to each individual client and might additionally constitute towards constructing an adherence measure for pluralistic therapy. However, as also discussed, such variations may also be due to more implicit factors such as the relative social positionings of the therapist and client in terms of gender, class etc. Previous research has shown that this might be a possibility; for example, Doran et al. (2016) found that ratings of negotiation in therapy sessions were related to ethnic differences between clients and therapists. Thus, there needs to be an investigation of the possibility of implicit factors, as well as explicit factors, involved in variations in therapists' interventions across clients. Further observational studies would be well placed to investigate these factors, although the implication of more implicit factors, for which there is no evidence that participants are treating these as important, might well be beyond the remit of CA proper (Stokoe & Weatherall, 2002).

9.2 Conclusion

The current study is the first to investigate how therapists pose questions about what might be therapeutically helpful to clients. As we have seen, these questions are actions which constitute a clear link between the concrete practice of meta-therapeutic dialogue and the institutional mandate in pluralistic therapy to engage in this practice. Despite some significant sampling limitations, the findings have illustrated some practical dilemmas and considerations arising, thus creating some practice-relevant findings from practice-based research. As such, the current findings represent a useful contribution to the practice and ongoing development of how therapists can create dialogical opportunities with clients, both within pluralistic therapy and in other approaches which adhere to similar principles such as collaboration and shared decision-making.

Appendix A: Glossary of frequently used CA terms

affiliation	When a speaker endorses or otherwise supportively responds to content in the prior speaker's turn e.g. emphatic agreement or displays of sympathy.
agenda, question	This has two components (Clayman & Heritage, 2002): 1) the *topical focus* of the answer as defined by the question 2) the *action* which the question makes relevant for the recipient to carry out e.g. to confirm yes/no; to give ideas; to explain/account for behaviour.
alignment	When a speaker conforms to a response made relevant by the prior speaker's turn such that they work together to bring off a particular activity e.g. troubles-telling or a question-answer sequence.
assessment	When a conversational turn evaluates something in the world e.g. a view, some food, a person's characteristics. Pomerantz (1984b) showed how assessments make relevant culturally-normative ways of responding.
closure-implicative	Features which show the speaker is moving to end a conversational turn and/or the current conversational sequence or focus e.g. a summary, which may also include an idiomatic phrase (Holt & Drew, 2005; Antaki, 2007).
complaint	When a participant negatively assesses another person or state of affairs. This other person may or may not be a party in the current conversation.
contiguous	When two elements occur next to each other. This is particularly important in CA when considering what turn-final element of a prior speaker's turn is contiguous what element at the start of the next speaker's turn. As noted by Sacks (1987), there is a higher relevancy for the next speaker to respond to the elements which are more contiguous with the start of their turn.
continuer	A minimal response from a recipient whereby they forego taking a more substantial turn, and so, enable the other speaker to continue talking. An important interactional feature of story-telling (Stivers, 2008), active listening (Fitzgerald & Leudar, 2010) and troubles-telling (Jefferson, 2015).
cut-off	When a speaker suddenly stops during or at the end of their production of a word. This is a type of perturbation, showing the speaker is orienting to some problem in responding or initiating an action (e.g. Silverman & Peräkylä, 1990).
design	The specific features of how a speaker produces or packages a conversational turn or action e.g. the different ways in which a speaker can format a question.
disaffiliation	When a speaker challenges or responds unsympathetically to content in the prior speaker's turn e.g. berating the prior speaker to "grow up" or producing strong, unmitigated disagreement like "You're talking utter nonsense".
epistemic marker	A feature which indexes the speaker's current epistemic stance i.e. a speaker can display more or less certainty regarding what they currently speaking about. Examples include "I guess", "maybe", "it certainly seems as if…"

extension	When the same speaker extends their turn past a point of possible completion of this turn e.g. continuing past on an initial question to provide a clarification or to put forward a possible answer to the question they have just posed.
formulation	When a speaker glosses or paraphrases what the prior speaker has just said. This can be used to show the recipient's understanding or to display empathy.
footing	The position or role a speaker takes on in an interaction e.g. speaking as themselves or speaking in the voice of someone else.
increment	When the speaker adds an extension to their prior turn *after* the recipient has not taken up an opportunity to substantially respond to this prior turn. This is important since it shows the speaker continuing to develop their turn after this lack of response by the recipient.
minimal acknowledgement	When a speaker minimally responds after the prior speaker has hearably finished their turn e.g. "Mhm", "Right", "Okay".
misalignment	When a speaker does not conform to the response requirements made relevant by the prior speaker's turn such that the prior speaker's action trajectory is delayed and/or otherwise disrupted.
overlap	When two speakers each bid to take the conversational floor by talking at the same time.
perspective-display	When a speaker shares their views regarding a state of affairs or topic (Maynard, 1989).
pivotal formulation	When a speaker glosses what the prior speaker has been saying in such a way that it forms the basis for a shift in focus or topic.
pursuit	When one speaker develops their turn in such a way to make it more likely that the other speaker will substantially respond e.g. using an **increment** (see above entry).
repair	When a speaker orients to some trouble in producing a conversation turn and re-does some of this production.
response requirements / relevancies	Actions which it is relevant for a recipient to perform given the prior speaker's turn e.g. answering a question the prior speaker has asked. The recipient is not bound to fulfil these response requirements, but they can be held accountable by the other speaker for not doing so and thus may need to explain why they are not fulfilling them.
troubles-telling	When a speaker describes a problem or difficulty at length. Miller & Silverman (1995) identified this as a key aspect of how counselling talk is organized.
turn-final	Features of a conversational turn which occur at the end of this turn.
upshot formulation	When a speaker constructs or suggests a main implication of the prior speaker's talk. Upshot formulations are frequently prefaced with "so".

Appendix B: Jefferson Transcription Symbols

(1.5)	= Timed pause (in seconds. Here is 1.5 seconds)
word [word	= Overlapping talk
[word	
.Hh	= In breath
Hh	= Out breath
wor-	= Sharp cut-off
wo:rd	= Sound stretched
word	= Spoken with emphasis
WORD	= Very loud talk
◦**word**◦	= Quiet talk
◦◦**word**◦◦	= Whisper
>word<	= Faster speech
<word>	= Slower speech
↑**word**	= Sudden rising intonation
↓**word**	= Sudden decreasing intonation
#word#	= 'croaky' voice
,	= Rising intonation
?	= Questioning intonation
.	= Falling intonation
(word)	= Uncertain transcription/audio unclear
((word))	= Transcription comment

Appendix C: Sample Statement of Permission from Principal Investigator

STATEMENT OF PERMISSION

I have reviewed the data protection and storage procedures for the doctoral research project of Sarah Cantwell, which will investigate appropriate responsiveness in *Pluralistic Therapy for Depression* (PfD).

I hereby give permission for the Principal Investigator, Sarah Cantwell and Dr John Rae, to use data from the *University of the West of England* PfD research site for the purpose of investigating appropriate responsiveness in PfD. This data will consist of audio-recordings of PfD sessions and of anonymized and quantitative information relating to therapeutic processes and outcomes.

When her doctoral research has been completed, I understand that Sarah Cantwell will undertake to destroy, beyond recovery, her copy of the PfD study data from the *University of the West of England* research site

Signature: ..... *Date*: .....

Principal Investigator
Pluralistic Therapy for Depression (PfD) study
(started 01/03/13; ended 22/12/13)

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Appendix D: Collection of 28 cases of therapists' questions about what might be therapeutically helpful

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Case#1

Extract AI *Session#0/Start54minutes/PairA* *(softened & de-specifying)*

C: ((continuing)) so what- (0.4) I've dHhone with that is that I try and have as le:ss contact with my mum, (0.5) as possible.
(.)
T: °Oki dokey.°
(0.5)
C: Ehm:,
T: .hh °eh-° (.) tell ↑me (.) Mary, >>have you<< ↑↑had any previous therapy?
(.)
T: Sorry to com[e ac]ross you there. [No?] .hh uhm have you got
C: [No.] [°No°]
T: any i:dea >>but I think that we- you said you had a friend who's a#: th[erapi]st, .hh do you have any i:dea abou#t, .h if
C: [Mm.]
T: there was a therapy, if you could choose a therapy [or something.]
C: [.hhh] I th:↑ink
T: °Anything in mind° [( )] you want to (g[ive me)]
C: [That-] [(the-)]
(.)
C: S: psychotherapy and then the one:, that (.) the- the family: (0.3) thing.
(.)
T: [Yeah.]
C: [Because] I think it's something that we all do in our f- >like my brother and sis:- we've all .hh (0.5) gone through little stages of it. >I think we've all got bits of .hh because like: if you speak to outside people >they say yeah because you ((continues))

Case#2

Extract OR? *Session#2/Start37minutes/PairA* *(softened & de-specifying)*

C: She: generall#y: has an issue with #i:t.
(.)
C: So::,
T: Mm: mm:.
(0.3)
T: .hh So this is, (0.3) quite a: >I mean I'm- I'm< >this is< is:
what I was: (0.3) sort of- (.) it- >well it is< it's- (0.3)
sort of a relatively=what I like about genograms #is that
th#ey're relatively simple t[o::]:
C: [Mm.]
C: .H[h >>↑YEAH 'cause it o[nly took [me a minu::t]e >>and then I
T: T[o draw [(or: [set up)]
C: was like<< o::h?
T: Yeah [but you know (a]::r) and s[tuff)] >we can MAKE them:
C: [>Uh Hih Hih<] [(Huh)]
T: (.) .Hh >we can make them bigger: as in [(our)] our
C: [Yeah::]
T: part[ner:s] and: (.) you know >whether we're with them: and:
C: [Yeah.]
T: ehm: who's (.) still with us: and: you know when: ehm your
↓da:d died so that sort of stuff .hh ↑uhm so >wh:at I normally
do: is partner this with: a sort of timeline=
C: O↓kay=
T: Um: as well >so we can have a look< and the timeline is >more
focuses on-< on you the things that impact on y#ou:=
C: =Yeah.
T: .Hh Uhm: (.) .tch so wh- what do you think about the:: ehm:
(0.7) your: (0.3) sort of genogram, (.) as it #is. ↑Shall we:
.hh ehm: I- >you- happy with that?< as a: as a representation
of your: (0.7) family >or the family that you want to talk
[abou:]t? or do you want to widen i:t? or:?
C: [.SHHIH]
C: .hh Uh↑m: (.) the- (.) f:unny thing is, is when you said about
uhm: wi:d#ening #i:t, (0.4) uhm: (.) I don't know what it #i:s
but my mum's (.) like (.) she's really funny: about family
trees=it's like- it's al:most like .hhh because I've got

Case#3

Extract HWYL *Session#4/Start47minutes/PairA* *(softened & de-specifying)*

T: ((continues)) .hh so we ca- we can also make sur#e=at the end of the sessions, th#at we've got time to have a look through: .hh like the genogram. Work as well.
C: yeah.
T: >And maybe until that's: (.) you feel like you've done enough on that?
(.)
C: Ye:[ah]
T: [S:]o: uhm: if that's something we wanna get in as well, I can keep an eye on the time:, .hh
C: yeah.
T: Uhm and: we can make sure that we: uhm: spend s- fifteen Minutes? Or someth[ing? Or >t]wenty minu[tes (or that)] before
C: [yeah.] [Yeah.]
T: we get to the end?=Does that ↑soun[d (alright).] .h[hh s]o:
C: [Yeah.] [°yeah°]
T: So what do you think. I've been throwing these ideas at you, bu- [(wha-)] how would you like a a session to g[o:.]
C: [Yeah.] [.hh]
C: ↑Ehm
T: >>What would you like me to do more of or less of:.
C: ↑I- (0.3) I- jh ↑realized like (0.3) uhm (0.5) I- t- I kinda felt that ↓we'd- it's really funny because we kinda uhm: (1.3) BOUnce off each other, so .hh as I'm thinking something then you bring it up and I did think- .hh I £said to e:hm (0.5) .shih my friend that (.) asked me ↑how are you getting on s#ort of thing, and I said to h#er: at work, and I said to her, I think I'm moaning too much and it's not getting me anywhere, because [.hh] the- like- it's not I don't need to
T: [M:m]
C: moan .h because it's all about (.) the same thing. so I said to her °this week I'm gonna talk less° but you've alREAdy brought it (0.3) up. .hh because I'd- I'd- what I wanna know:
((continues))

Case#4

Extract WHAWGT *Session#8/Start41minutes/PairA* *(softened & de-specifying)*

C: And I'm th↑inking, don't you realize he eats and he needs
clothes and- .hhh so#:
T: Ye:[ah.]
C: [She]'s just as bad as him. that's wh[y ( )]
T: [YE::AH]
(.)
C: [He is. [so] maybe she needs a (lift)
T: [(Yeah) [(no)]
T: ((laughter)) Ma(hih)ybe .hh >WE[LL-] how are we going to
C: [Yeah.]
T: tackle this letter then.=shall ↑we- (.) ehm: °wh-° what do you
reckon (of that). 'cause .hhh ehm you know, it ↑might-
(>recall lots of that) but wha#- I guess what- (0.6)
↑something going through my mind i#s: .hh we could sta#rt it
in some sort of chronological order:, so:, .hh we could sor-
maybe start >with like< when you first (0.3) met him: and what
your aspirations w#ere and all of that:, [and the]n: when you
C: [UM:]
T: got pregnant and (.) what happened after that or someth↑ing?
.hh wh- [wh-]
C: [I] WAS-
T: What w[ould be your i]dea,
C: [(I guess)]
C: ↑Everything- everythi#ng- uhm I do no#w:, (0.8) #and
#everything I've d#one:, (0.3) >I was always going to do when
I met him. [.hh] Bu:t (.) the on:ly thing is: >I didn't want

Case#5

Extract AM *Session#1/Start13minutes/PairB* *(minimally softened)*

T: .tch .hh eh:m OR: we could use what's known as client cent:ered technique of:=you: talking about whatever it is in your mind,(1.0) as we go through the sess:ion=
C: M:m=
T: =An:d .hhh (0.5) and I try to faCILitate and help you to explor:e these issues in greater depth. your↑sel[f.]
C: [Ye:]ah
T: Without using any .hh particular technique or, strategy .shihh
C: °Right.°
(.)
T: .tch .hh >Which as I say< is a <client centered [type] of
C: [M:m]
T: facilitative counselling> typical counselling in actual fact. [what] °a lot of people would think of as counselling.°
C: [Ri:ght]
T: .HH .Shihh OR: WE: can ↑do: a ↓combinat:ion of ↑these thi:ngs:
C: °Yeah°
T: °Do° different thi:ngs: (.) try=and, look at ↑all of those th↑i:ngs.
C: Mm
(1.0)
C: >You're gonna ask me what I< think now ↑aren't yHHo[uHH]
T: [I'm g]oing to ask you if you've got any thoughts ↑yes abou:t [whether [you have] a preference:? ↓what you think would be
C: [HHH [.shihh]
T: Be[st:: .hhh]
C: [I don't really] have a preference °to be honest° ↑I'm eh:m (0.7) [↑I'm-]
T: >[There] ARE, there are some other thoughts actually that occur to me. We could< adopt a: a kind of a so↑lution focused? approach?

Case#6

Extract ISLY *Session#1/Start17minutes/PairB* *(substantially softened)*

```
 1  T:   .HHH Relaxation is learning to brea:the Hh [nice ] and
 2  C:                                              [°Mm.°]
 3  T:   steadily: and slowly and (1.0) [ca:  ]lming your physiology
 4  C:                                  [Yea:h]
 5  T:   down a bit.
 6  C:   Mm.
 7  T:   .Hh So, (1.9) >coming back to you again< we've talked about a
 8       range of thi:[ngs that one] might think about? s::: do you
 9  C:               [Yea:h.      ]
10  T:   have any: (0.6) .hh °i:°t sounded like you liked the thought
11       of being a bit more solution focu[s:ed?]
12  C:                                    [Yea::h a bit positive.
13       (0.4)
14  C:   Ye:ah.
15       (0.4)
16  C:   I think so.
17       (1.5)
18  C:   °M:m.°
19       (0.7)
20  T:   .pch Having said that, (0.5) this might not be a problem
21       ((continues))
```

Case#7

Extract SC1 *Session#3/Start37minutes/PairB* *(substantially softened)*

T: >So those are< (0.3) kinds of questions °th~at° we °might think abou:t?°
C: Yeah.
T: .h Or you might think about. .Hhh ehm: >you know< what is it do you thinkH that ↑might help you to move on H from this point? >Do you have any thoughts< about that=°does° has anything occurred to you:?=#a:s=has the family thought about memor:ial se#rvice=h#ave you,=
C: =Well we did. we ACTually thou:ght ehm: (0.5) °it was ↑quite- >sort of relatively-< soon °after ((continues))

Case#8

Extract SC2 - *Session#3/Start40minutes/PairB* *(minimally softened)*

T: But >it doesn't have to< s:top (.) other people doing: what th[ey need to do]
C: [They feel] ye:ah.
(1.3)
T: .Hhh
C: °Yeah it's true°
(0.5)
T: ↑Do: you HAVE ANY THOUGHTS about:?
(1.1)
C: I mean I: wo[uld like to [do-]
T: [Or what do y[ou:] need, do you think. what would help you to- Hhh
C: I've ↑always thought I'd like to someth- you know, if nothing el:se, I'd like to go ↑over there, for the day.

Case#9

Extract WBRH *Session#0/Start29minutes/PairC* *(minimally softened)*

C: °I just° (0.4) then she w#ent through a c#ouple of ex#ercises,
and breath#ing, (.) exerc#ises °as we:ll, and that was,°
(2.3)
C: H#elped a b#it b#ut, (0.6) °no.°
(0.4)
T: .pch What- >>↑do you have a ↑sense<< of what would be really
helpf°ul for you.°
(1.8)
C: HHHHH
(0.8)
T: What is i[t (y-)][Mm:]
C: [If I KNEW what would be helpful][I'd,]
(0.4)
C: °I could go° and ge:t it.
?: .SHHIHH
(0.5)
C: I'd l#ike to be a millionaire and spend thousands in therapy,
°but° .shih H °°that wouldn(h)'t work°°
(0.3)
C: >(IT) MIGHT HELP, (.) >>but you know what I mean?
(1.5)
C: I ↑↑just maybe:, (2.9) >I've GOT a CONNECtion WITH THAT DOCTOR
((continues))

Case#10

Extract HDWGT *Session#2/Start9minutes/PairC* *(minimally softened)*

T: And d'you- but- (0.8) and: pre↑sumably, you can:: (.) change that.
(1.9)
C: I hope I can?
(0.8)
C: If I can stop- pro[bably] two and three.
T: [Yea:h]
(0.7)
C: °For- (0.3) for-° (0.3) [(something like it)]
T: [So how do we:,] how do we get that up to a hfo(h)ur.
C: H ↑↑Hah it's not on=
T: =So >that'd be the ne[xt (thing and)]
C: [That's]
(.)
C: ↑I don't know >that's why I came to you: .h No:: that's: [I]
T: [How]
>how can we get it up to a four< what would that actually mean.
(.)
T: .shih to do something=I mean in your life at the mo:ment, what would that mean doing (.) that was a bit more risky.
C: Say from a work point of view, (0.4)
T: Yeah.=
C: =I was off for °four months last year°. .hhh and I came back
(0.6) and the concentration wasn't there ((continues))

Case#11

Extract SWCYBD *Session#2/Start11minutes/PairC* *(minimally softened)*

C: [I should] be there if I
T: [.HH] [So WHAT]
C: wasn't [(the whole)] last year down and out but, (0.5) °it's a
T: [Yeah.]
C: good thing in a way,°
(.)
T: Mhm.
C: °If everything was okay I'd like to be,° (0.7)
T: So [what co[uld you] be doing in your life now: (0.3) that
C: [H [HH]
T: would be >taking a bit more of a risk.
(1.4)
T: [Like i]n: re↑lationships o[r: whatever.]
C: [Eh::] [Oh ye:ah] a bit bit more.
(0.6)
C: Spend a bit more when I'm out, (0.6) and make a bit more of an effort with people.

Case#12

Extract SWWTM *Session#2/Start13minutes/PairC* *(minimally softened)*

C: ((continuing)) .hh I'm only attracting these crazy, (2.6) one of the girls was more: sk- Breda she's in there.
(1.1)
?: .shih
C: So. .SHIH HHH I J- JUST THINK emotionally sometimes take more of a riskh.
(0.3)
T: So wh what would that mean to take more of an emotional risk then.
(.)
C: ↑Just SAY:: ask someone I like, >I said< do you wanna come for a coffee and .HH I can DO THAT BUT (0.5) ↓saying (0.9) do you wanna go out together or whatever, that's the kinda (0.7)
((continues))

Case#13

Extract HCYM *Session#2/Start14minutes/PairC* *(minimally softened)*

C: ((continuing)) I quite like her °but no° (0.6) that's not on.
(2.5)
C: °That's about it.°
(1.3)
T: .Hh SO:: u:: kinda part of the reason might be H (0.3) how how: could you meet more: (0.3) women ↓then.
(1.0)
C: °↑That's the° >maybe go out a bit more instead I- I TEND TO DRINK in >you know like< old man's (.) drinking pubs or whatever. .hhh And when my other pals go, I go na:: (.)°I'm: not feeling too good.° H
T: [Ri:ght.]
C: [(Th-)] They wanna go ((continues))

Case#14

Extract WIIYN *Session#2/Start17minutes/PairC* *(softened & de-specifying)*

C: I'm great at analysing myself yeah: >you can- you should do this you should do tha:t.
(0.5)
C: You can do this a lot:, [or t]ry that.
T: [Mhm.]
(0.7)
C: °But,°
(.)
T: >What is it you think you need to< do.=I mean if- if a situation li:ke .HH with: with friends and: and >going out to kinda a younger person's pub rather than a kinda< old man's pub,
C: Uhuh.
T: .Hh What is=it that you need to: do, (.) to: change: >your level of risk.
(0.6)/ ((movement of chair))
C: Don:'t overdo IT- WELL: I should- go OUT MORE
[and: (I shouldn'-)]
T: [Ri:ght]
?: .HH
C: I shouldn't ei:ther: (1.0) °be either ((continues))

Case#15

Extract WIITGH *Session#2/Start19minutes/PairC* *(minimally softened)*

C: It didn't last long >but I ↑mean< (0.3) ↑why am ↑I doing all the hard wor[k.]
T: [N]yeah:.]
(.)
T: .HH [(What has-)] [I gue-]
C: [(I'll-)] [I'L]L DO IT FOR SOMEBODY ELSE but, (0.6)
T: .pch But it's safe[r isn't i:t.]
C: [I wouldn't >I would]n't< do it °for myself.°
T: .Hh But there's a safety thing there [isn't t]her::e=it's
C: [↑Oh yeah:.]
T: safer.
(.)
C: °Uh#uh.°
(0.8)
T: .Hh So WHAT DO YOU NEED TO:- .H I mean, wh- WHAt IS it that's gonna help you take that risk.
(.)
T: >'Cause is i:t- .sHHih is it really >that you need what- >to- to know what to do.< 'cause it ↑sounds like you know what to do.
(.)
C: It's j↑ust confidenc[e.]
T: [C]onfidence.
C: °Y#eah. >S'I can- (.) [( ) [TALK and [WHATEVER)]

Case#16

Extract WITBR *Session#3/Start35minutes/PairC* *(minimally softened)*

C: Someone to (treat) you=↑ah that l↑ooks good >↑oh somebody likes me=or loves me? [°(you know the way< or)] whatever,°
T: [Yea:h.]
(2.4)
C: But, (.) I suppose, (1.4) ((movement during pause)) ↓maybe, (3.0) °I wanna be kind of happy=but.°
(0.9)
T: What's the best ar:g- I mean when that voice says (.) you're ↓nothing, (0.5)
C: °Uhuh.°
T: .hh wha- what is the best response to that.
(1.7)
C: °I don't have a response to it=that's the thi[ng° I just]
T: [Nyea::h]
C: agree with it.
(0.4)
C: THAT'S THAT'S PROBably:, .hhh (1.0) °that is the answer .pch or not the answer the question,=
T: =NO:=(>>I think<<)=you are=I think that's- that- in a way=that's the core of the problem isn't it.

Case#17

Extract AWE *Session#11/Start8minutes/PairC* *(minimally softened)*

C: °I was thinking too much.°
(1.2)
T: Well I guess- (.) I- I guess maybe ↓wh:at it's about >°that you've-° (.) >you've (gone)=rather than analysing it< you're going out and doing:, °.shih° (0.7) ((sound of movement in this 0.7 pause)) °and making those changes.°
(.)
C: °Uhuh.°
(.)
T: And arou:nd=so: >that that< sounds like a plan to go out and do: (.) five a side (.) footb#all=what would that be=once a week?
(.)
C: °That'd be once a week yeah.°
T: And what else?
(1.1)
C: °I've not been (checking those)° HH hthat's:H ((movement of chair))
(0.3)
C: .Hh That's too much like the MPT girls.
(0.9)
T: .H >No I mean >>y'know- well:< before I get on toHHiH .hh H >We(h)'ll come to that.< .h what about oth- >what about exercise:< >so that's once a week.

Case#18

Extract WWBAG *Session#11/Start9minutes/PairC* *(minimally softened)*

T: And that feels okay:y.
(0.3)
C: It ↑feels [okay:]: ↑well- (.) HHH s: the las:t ↓four
T: [(Does it.)]
C: (0.6) month (0.4) I've not been do#ing #as m#uch H and then
(at the least) Hh >I'd be (wore) out of puff.
(0.8)
C: (Flights) like [them.]
T: [Ye:ah.]
C: But,- (0.3) °no:=I like- I l↑i:ke doing that.°
(0.3)
T: I mean >WHAT WOULD BE a good ROUTI:NE,< >what would be a good
amount< to do.
(.)
T: Ih- #eh::- kinda on a weekly basis.
(1.0)
C: I ↑normally used to do it four or five times a week (0.5) and

Case#19

Extract BTWA *Session#11/Start13minutes/PairC* *(minimally softened)*

T: Mhm.
(1.3)
C: I ↑ca:- I c:an (blab) (.) to:, (0.5) most people.
(1.4)
T: °↑'kay.° .HHH An:d okay so tha:t- >th↑at seems like a really good plan< about kinda- getting to mo:re (.) exercising, (0.4) .hh but then what abou:t, meeting:: (.)°women.°
(0.9)
C: (And won't there be few.)
(.)
T: Eh?
(.)
C: °-oh-=oh-° I'm h- hoping: (.) Sal- Sally .hh I'll get some (0.4) friends, (0.3) I'll- (0.3) talk away to them but, (0.7) °I've not really m#ade pl#ans, (.) to be (.) something serious.°
(1.0)

Case#20

Extract SWAWGD *Session#11/Start20minutes/PairC* *(minimally softened)*

C: ((continuing turn)) that's that's how I: dealt with it (.)
[↑↑they think-] thought it was quite funny
T: [Yeah]
T: Yea:h NO >I can iMAGine it was funny< but it CAN also be a way
of kinda keeping people at a distance ca[n't it.]
C: [Yes-](.)°oh° ↓yeah.
(0.3)
T: °Through humour.°
(1.1)
T: .HH SO SO OKAY >so you're NOT GONNA go on=online< dating, (.)
so >what what are we gonna do< about °you: a:nd°
relationships.
(0.7)
C: HHHHH
(0.7)
C: (I expect) (.) ye:a:h=that's: °a good thing°
(1.7)
T: That's a good, (.) question=
C: =THAT'S A GOOD QUESTION [I CAN]
T: [( )]
T: Hih heh heh what we(h)re your(h) (th(h)e) funniest one
C: NO that's a good question, I- d- HH
(1.6)
C: That's something I'll have to change, I don't know. (0.9)
T: .PT [>Do you THINK-<] I mean I KNOW what you mean, >it's
((continues))

Case#21

Extract TTH *Session#0/Start31minutes/PairD* *(minimally softened)*

T: ((continuing)) really focused on your anxIETY< .hh but if it FOCUSes on something positive like ↓you know doing something like therapy, we:ll then it can be a really positive .hh quality .h

C: M:m

T: °And ability to be able to ↑do:.°

(0.3)

C: M:hm

(0.3)

T: .HH So WHAT- >I mean IN TERMS of the THERapy here< what's what's your: sense of it, wh=wh=wh: what's your thinking about what you'd like to °do°.

C: .HHH H

(1.0)

*?: °.shih°

(1.9)

T: Or I could tell you my thoughts.

C: ↑Yeah, I'd be interested in you[r tho]ughts, I mean-

T: [°'kay°]

(0.4)

C: ↓Very generally just- (.) °what I'd said before°, just- .hh

(0.3) a little help-ing hand would be: (0.4) rea:ll[y]

Case#22

Extract BW *Session#2/Start22minutes/PairD* *(minimally softened)*

C: >and I wa:nt< to (0.3) de:al w#ith h (0.3) ↑THIS bit that's coming .hh in the: most construct[ive l]least energy expe(h)n-
T: [°yeah°]
C: least emotional en(h)er#gy ex(h)p#ending way .hh °°cause I just°° feel so exhau:[sted]
T: [↓Yeah I b]et
(0.4)
C: [I ↓re::::ally] [↓(no:w)]
T: [°We°'ve both been >talking about] [it and think]ing about it< all the t[ime, and=it's] >going round and round in your ↓head<
C: [Yeah=h]
(0.3)
C: °Ye:ah°
T: .Hh So ↑what would that °umph° ↑what w-:OUld- b:e- (.) the-best (0.3) way °of dealing with=it.°
?: .hh °.shih°
(6.0)
?: .PT
(1.2)
T: >It's UNpredictable >and it's a difficult [question isn't=↓it=cause (th-)] .hh you- >DON'T KNOW WHAT HIS
((continues))

Case#23

Extract HCYDT *Session#2/Start34minutes/PairD* *(minimally softened)*

C: [>I want it to] be the ↑#other #way #ar↑ound<
T: [Ye:ah]
C: SHHih. HHHEHH[h]
T: [Ye]:ah
C: hh. .shhih
T: h. >And I guess< and ↑how- ↑how can you do that?
C: °.shhhih M::m,° (0.8) °°brain transpl[ant°°]
T: [hehheh] [heh hahhah] hah
C: [hih ha hah]
C: °Oh God° .hh hh (0.8) °I dunno:°
(1.0)
C: ↑Being in a state of hypervigilence all the ↑time, and then sitting down and examining every emotion and .hh whether it's valid or just (.) non↑sense? .hshih °°that sounds°° a hell of a lotta wo[rk.]
T: [It]does doesn't i:t?
C: °Uh ha:h° >but it's<- it #actually sounds quite necess(hh)AR(hih)Y wo(hhh)rk. (.) .shhih

Case#24

Extract HWT *Session#9/Start2minutes/PairE* *(minimally softened)*

T: Eh khem (.) so but (0.3) it seems like your: (0.5) sleep is related to not (.) liking the dark?
(2.0)
C: Yeah.
T: °Okay.°
(0.4)
C: °I think so.°
T: °Mhm° .hh ↓is there anything you can do that would help with that.
(0.5)
T: [Like]
C: [.hh] Ehm, .hh H I've been doing like, (.) audios you g#et on the internet for like s#ort of relaxing, ((continues))

Case#25

Extract AIP *Session#4/Start1minute/PairF* *(substantially softened)*

C: Even when thing:s >kind of< have gone a bit wrong:? [or:] have
T: [Mm.]
C: kinda come up, .hh
T: °Yeah.°
C: >I seem to have been able to< (.) deal with it a lot
bett[er?=an]d I don't get as kind of, (0.4) into like a state
T: [Right.]
C: a[n:d, .hh]
T: [Right] right.
(0.7) ((rustling of paper during this pause))
T: °↑Okay° that's really good.
(0.5) ((rustling of paper during this pause))
T: °↑Okay°
(0.4) ((rustling of paper during this pause))
T: So then as far as <goals go,> .hh so you're finding:, °umph°
(0.6) °eh-° kind of like a m- a middle:: (.) ground for all of
them?=is .hh there anything in particular that you would find
that you would want us to do more to make sure you're
reaching: your goals a bit mo:re? O[r,]
C: [Eh]m:,
(0.5)
C: .hh I th↑ink >just kinda< keep keep going the way we are: I
mean I've fe:lt, .hh I've noticed, ((continues))

Case#26

Extract AEYTMTE *Session#3/Start23minutes/PairF* *(substantially softened)*

C: ((continuing)) stay ↑here th#en.
T: .Hh So kinda things like, (0.3) vi- n:ot always thinki:ng that he's right kinda being able to (.) to listen to: y- your side of things a bit mo[re, .hh] and maybe
C: [M:m.]
T: >kinda something about him< taking initiative more? [A:nd,]
C: [Ye:ah.]
T: yea:h .hh ye:#ah.
(.)
T: Mw- >is there anything else< you think .hh that maybe would- m:ake things easier?=for you, °so you don't get so stressed ou:t? #Or?°
(0.9)
C: .pch (0.3) >↑I don't know.< I th↑ink (.) tha:t (.) it's (0.4) it's: kinda of hhh (0.4) .tch (0.8) I ↑just th↑ink there's #ah- >I think he thi-< (.) >being completely honest I think he just needs to< (.) <gro:w up> a little [bit?]
T: [Mm.]

Case#27

Extract SWWYS *Session#3/Start28minutes/PairF* *(substantially softened)*

```
 1  C:   stupid, (.) ~an:d, (0.9) I think .hh I need to sit and have
 2       (0.5) a- (.) serious >kind of< (.) proper discussion=make him
 3       re:alize that there [is a s]erious thi[ng,] .hh
 4  T:                       [Mm.   ]          [Yea]h.
 5  C:   And then if it doesn't change I'll have to:, (0.8) just say to
 6       him look, (0.6) maybe we need some ti:me [ap[art?] and just
 7  T:                                            [M [hm  ]
 8  C:   see: [.hh ] see how th↑at g#oe[s.  ]
 9  T:        [Mhm.]                   [Mhm.]
10  T:   .hh So ↑what would ↑you say to him to make him realize=like
11       ho:w- much of an impact he's having? on y#ou: and h#o:w .hh
12       °b-° badly you're f↑eeling b- (0.6) because of what's going
13       o:n.
14  ?:   h .h
15       (0.3)
16  C:   H:m.
17       (1.3)
18  C:   .pch=↓That's the thi:ng, I don't really know how to: (0.5)
19  T:   °Mhm:.°
20       (0.6)
21  C:   .pch I think it's: .tch=kinda as you ↓sa:y=I think  I just
22       have to get everything written do[w:n  ] an:d, .hh just say
23  T:                                    [Yeah.]
24  C:   ↓look there's this and there's this and there's this a[n:d,]
25  T:                                                        [M:  ]m
26  C:   (0.5) an:d, kind of (.) >just say to him< look I: (0.8) ↓I:'m
27       (0.4) >kind of< (.) working through a lot of stuff an[:d I'm]
28  T:                                                       [Mm.   ]
29  C:   obviousl#y, (0.5) I feel a lot better no::w [but,] .hh I need
30  T:                                              [Mm. ]
```

Case#28

Extract ATCBD *Session#1/Start25minutes/PairF* *(substantially softened)*

C: =.tch That kind of th#ing: hh
T: °Right°
(1.0)
T: °Yeah:° >so just feeling like< you wanted (.) to: help
a[nd: it] kinda (.)↓didn't re#ally g#o: the w#ay you w#ere
C: [M:m]
T: ex[pecting it.]
C: [Ye::ah] >eh ↑h[uh<]
T: [Ye]ah:
?: .hh hh
T: ↑So then do you think that uhm: (0.4) °.tch° (.)°umph°
there:'s anything that can be done- (.) °umph° uhm: >in
preparation so you< don't become: so that the stress kinda
doesn't pile: up: in: a situation, such as Ben's
fam[ily coming] .hh that: maybe you can- (0.3) prepare for: or
C: [M:M]
T: kinda say things to Ben: .H maybe when they're there:, just:
to: kinda make sure that .hh you don't end up °umph-° with
this °eh-° massive amou[nt of stress] [(Ri-)]
C: [Ye:ah:] [I] think ↑if- I
th:ink, .HHh at the MO:ment, I'm just gonna have to be: (.)
not s:elfish, but what >>I would consider being selfish which
which<< [is] .HH if something happens and it really
((continues))

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